States · of · Guernsey
BOARD OF
HEALTH

102nd ANNUAL MOH REPORT

and

SEVENTH ANNUAL REPORT of the DIRECTOR OF PUBLIC HEALTH

Special Theme:
'Health and the Environment'

THERE! ... THAT'S BETTER THAN SITTING ALL ALONE IN YOUR CAR EH!
?
BUS STOP
CAR-FREE DAY
USE-A-BUS ....
.... IT MAKES SENSE!

REPORT FOR
THE YEAR 2000/01

BOARD OF HEALTH

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Health and environment in Guernsey

- The stricken Italian-registered chemical bulk carrier '*Ievoli Sun*' slowly founders off Alderney (October 2000)

- Our participation in European '*Car-free*' Day (25th September 2000) attracted much media comment ....

Acknowledgments: '*Wakky*' – the late Alan Wakeford,
Reuters and Guernsey Press Limited

STATES OF GUERNSEY

BOARD OF HEALTH

Objectives

To maintain and improve the health of the people of Guernsey & Alderney as cost effectively as possible, within the resource constraints placed upon it by:

- Identifying health needs - now and in the future
- Planning the future provision of health services to meet these needs
- Commissioning the provision of these services
- Ensuring that the quality of health services provided is high and standards are maintained through careful monitoring
- Ensuring that only appropriate and effective care or treatment is given, by monitoring the outcome of such interventions
- Listening to the customers in order to understand their needs and working with others so as to best meet these needs
- Informing people on health matters, promoting a healthy lifestyle and environment
- Acting as a 'caring neighbour' and considering the environment for future generations
- Checking that all health services provided are as cost efficient as possible
- Promoting managerial and professional excellence within health services
- Recruiting, training and developing sufficient health care staff to achieve these objectives and valuing the staff and helping them to meet their needs and objectives

INTRODUCTORY LETTER TO THE BOARD OF HEALTH

October 2001

The President
States of Guernsey Board of Health

Dear Sir,

I have pleasure in submitting the 102nd Annual Report of the Medical Officer of Health for Guernsey for 2000/2001.

Yours faithfully,

Dr David Jeffs
MEDICAL OFFICER OF HEALTH
Director of Public Health

HIGHLIGHTS FROM THIS REPORT

- Widespread flooding in England during the wettest year on record since records began in 1766 and concerns about greenhouse gas emissions, global warming and the failure of the US to endorse the Kyoto protocol have all served to focus interest on health and environmental issues.

- The opportunity has therefore been taken to review environmental issues which impact on population health in Guernsey and more widely, and to review progress in several of these areas.

- Against rapidly rising real estate prices, there are still mothers with young children and other vulnerable individuals forced to rent unsatisfactory housing within the private sector. There is obviously no one simple solution, but reviewing, simplifying and facilitating the process for development applications would be worthwhile if this encouraged urban regeneration and an improvement in the quality of such rental properties.

- Problems also exist in several of our States housing areas, and again better joint working between various States Committees, as occurs in "Health Action Zones" in the UK, might help address some of these long standing problems.

- Although the concept of sewage treatment within an overall "liquid waste strategy" has been accepted by the States, final decisions have yet to be made on the preferred technology and suitable siting for such treatment. In the meantime, our discharge of raw sewage continues to attract adverse comments from visitors and has resulted in the automatic loss of *'Good Beach Guide'* "Recommended" status for several island beaches.

- The situation is more urgent regarding solid waste management, with our sob remaining large landfill site being filled at more than twice the rate once predicted. Implementing a *"waste to energy"* plant along with associated measures must be a priority if the island is not to run out of landfill space during the next 10-15 years.

- The lack of an integrated traffic strategy is identified as the *"biggest single unresolved environmental health problem"* facing the island. It is pointed out that the present growth (and usage) of private motor vehicles in what is essentially a fixed road carrying capacity is not sustainable. Decisions taken in isolation (such as additional urban parking) will displace rather than solve the problem. Only an integrated transport strategy has the potential to persuade car owners to reduce car usage for some journeys.

- Real-time air quality monitoring confirms that the main source of atmospheric pollution in Guernsey is now undoubtedly motor vehicles working inefficiently in low gear on our overcrowded urban roads. Peak pollution levels in the morning and evening rush hours are regularly twice background levels and those found on Saturdays, Sundays and Bank Holidays when commuter traffic is minimal.

- A potential major chemical incident involving the Italian chemical bulk carrier *'Ievoli Sun'* reminds us that the islands are still vulnerable to external environmental threats. It is essential to have access to specialist advice and to implement appropriate responses across the variety of agencies involved if population health is to be protected following such incidents.

- Environmental issues have a global as well as a local dimension. It is pleasing to report that the island has accepted the concept of appropriate *'Indicators of Sustainable Development'*, and these will be progressively developed over the coming years.

- A health promotion "priority setting exercise" carried out by a group of informed "opinion leaders" has led to a re-formulation of 20 leading health promotion priorities. Addressing inequalities in health is a theme which will run through all programmes.

- A *'Health Strategy Unit'* has recently been established to bring together the previously separate functions of "health information" and "ensuring clinical quality". An early task of the *'Health Strategy Unit'* will be to develop a short list of suitable "clinical indicators" in order to compare clinical performance and health outcomes at the Princess Elizabeth Hospital with similar hospitals in the NHS and elsewhere.

- *'Clinical governance'* is an umbrella term for those activities which result in the delivery of high-quality clinical services and excellence in health outcomes.

- A start has already been made on establishing structures to ensure good *'clinical governance'* in Guernsey. These include: clinical audit, clinical risk management groups, a monthly *'academic half-day'* for all specialists at the Medical Specialist Group, more structured "continuing professional development" and similar activities amongst primary care practitioners.

- It is important not only that good-quality clinical services be delivered and demonstrated in Guernsey, but also that it be possible to benchmark these against accepted external standards.

- The lack of "joined-up Government" is suggested as the biggest single barrier to the most effective measures being taken to protect the environment and health in Guernsey. The recommendations of the *'Harwood Report'* on the Machinery of Government if implemented would do much to improve our ability to protect and improve our own local environment, our quality of life and health and our responsibilities to the wider world community.

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Acknowledgements:

Effective public health remains essentially about teamwork, and once again the contributors to this Report and the work of all public health directorate staff are acknowledged, especially that of Miss Corinne Joy for typing and compiling much of the Report and of Mrs Jenny Elliott for the various graphs.

Chapter One

Health and Environment in Guernsey

The global perspective

"In a world afflicted by murder, mayhem and malnutrition, it may seem bizarre to suggest that the worst thing to happen this year is for some words to come out of man's mouth – but that may turn out to be so. Last week President Bush reneged on a campaign promise to regulate emissions of carbon dioxide from power stations. This is a serious set back in a world that is already failing to respond responsibly to global warming. The short term effects of Bush's decision may be merely political but the longer term effects are likely to be catastrophic ..."

"There are few scientists left who doubt, firstly, that global warming is occurring and, secondly, that the warming is caused mostly by emissions of greenhouse gases resulting from human activity ..."

"The expected effects of global warming are not entirely clear, but interference with systems as complex as weather can have drastic and unpredictable consequences. Most likely are flooding, the drowning and displacement of millions, destruction of arable land causing widespread malnutrition, highly destructive weather episodes, deaths from higher temperatures and the geographical extension of diseases like malaria".

BMJ, 24th March, 2001

The above sentiments from an Editorial in the normally conservative *British Medical Journal* ("BMJ") were echoed in many other major and mainstream scientific publications.

They followed the announcement by newly elected US President, George W Bush, that his administration would not ratify the Kyoto protocol to limit greenhouse gas emissions. Since the US contains only **4%** of the world's population, but produces a much publicised **25%** of the world's greenhouse gas emissions, failure to progress the fairly modest proposals contained in the Kyoto Agreement at the very least leaves the world facing a more uncertain future and almost certainly a less healthy one.

This interdependence between the environment and human health is so important that *"Health and the environment in Guernsey"* has been chosen as the "special theme" of this 102nd annual MoH Report. The opportunity is taken to review progress in achieving local environmental health objectives and to comment on more global issues as they affect Guernsey.

Health and the environment in Guernsey

The Board of Health was born in 1899 following an outbreak of diphtheria which resulted in 121 cases and 23 deaths from this disease. A special Committee of the Royal Court had reported:-

"The main causes of the outbreaks of diphtheria, scarlet fever and enteric fever was the unsanitary state of certain houses and localities due to defective drainage, cesspools, accumulations of household refuse, manure heaps and pits, pigsties, latrines etc. in close proximity to drinking water, making a source of constant danger".

The measures taken to bring this outbreak of diphtheria under control and to tackle many of the other local environmental factors which made the island prone to such outbreaks have been well documented in previous MoH Reports. They are also summarised in the recent Board of Health publication *"One Hundred Years of Health"* (Board of Health November 1999) which summarises *"the changing health of Guernsey and Alderney"* during the first century of the Board's existence.

However, although many environmental influences which may impact on health in Guernsey have been addressed, our successes are by no means complete. Important issues requiring further resolution include:

Rental housing

The links between housing standards and health are well established and were a frequent cause of concern to previous MoHs. In 1921, the then MoH, Dr Henry Draper Bishop wrote:

"It is the duty of an MoH to consider the housing question as one of the most important questions with which he is concerned, and when looking over my past Reports, I find that I have devoted a great deal of space year after year to this question".

It is therefore sad to report that some 80 years later, as the island enjoys a new period of prosperity, there are still many individuals and even mothers with young children whose housing conditions verge on being *"unfit for human habitation"*. From time to time it is also still necessary to issue a "closure notice" on premises in the private sector which fall below even this fairly basic standard.

Ensuring adequate standards within the private sector is not easy. In our present "overheated economy" most properties (even those in an unsatisfactory state of repair) are let quickly, and some landlords will consider there is little incentive and often only heartache in trying to upgrade such premises.

Additionally, many of those forced to occupy the cheapest rented housing are the most vulnerable members of our community, including single mothers and those with previous mental health or substance abuse problems. They are therefore often reluctant to complain for fear of losing what little physical security their unsatisfactory premises provide. The small number of "closure notices" actually issued reflects undoubtedly just the tip of a far larger "iceberg" of properties in poor repair.

In the Draft Strategic and Corporate Plan for 2000, the States have agreed *"to achieve as much new housing as practical and possible within the existing urban areas"*. Some landlords and developers would suggest that our whole approach to redevelopment needs to be simpler, more streamlined and much more timely in reaching decisions if this is to be achieved.

Public sector housing

However, problems do not just lie within the private sector. Some poor designs, ongoing vandalism, violence and intimidation of residents, excess crime and social problems are to be found in several of our areas of States housing, and reports from residents suggest that these are perceived as being just as serious as in many inner urban housing estates in the UK.

The formation of the Bouet Action Group, mobilisation of local opinion, effective joint working between the Police, Housing, Health and other relevant States committees and a commitment to limited re-building all offer some hope for the future. The reported successes of "joined-up" action in the *"Health Action Zones"* in the UK proposed in the White Paper *"Our Healthier Nation"* in 1999 confirm that progress and success are possible.

Sewage treatment

There is perhaps a certain irony that primary sewage treatment should have been the most popular single nomination for a Millennium "commemorative project". However, despite such apparent popular support, and despite "agreement in principle" by the States in 1997 to treat sewage as part of the overall "liquid waste strategy", progress (on the ground) continues to be painfully slow with final decisions yet to be made on the preferred technology and suitable siting for such treatment.

In the meantime, untreated sewage continues to be discharged through the Crève Coeur outfall directly into the Little Russel. Although this practice probably has minimal impact on our local population health, many would consider it as environmentally undesirable, and the news that Guernsey as a would-be "clean and green" tourist destination still permits discharges directly to sea frequently produces incredulous disbelief amongst many visitors, as well as more tangible detriments such as the automatic loss of "recommended" status in the *'Good Beach Guide'* for all beaches within five kilometres of such outfalls.

Solid waste disposal

Progress has been slightly better with regards to solid waste, with a States commitment to a *"waste to energy"* plant and a preferred site now undergoing more detailed evaluation. However, with solid waste the need is more urgent with our last usable "hole in the ground" at Mont Cuet being "land filled" at more than twice the rate at one time predicted.

Any further delays in bringing a *"waste to energy"* plant to fruition, along with implementing essential associated measures such as improving waste reduction and increasing environmentally and economically justifiable recycling and the re-use of waste products, could well result in the island running out of land fill space within the next 10-15 years.

An integrated traffic strategy

Perhaps the biggest single unresolved environmental health problem is our lack of an integrated and comprehensive traffic strategy. During the past 30 years, the number of private motor vehicles has shown a **110%** increase (from 17,416 in 1970 to 36,460 in 1999).

There has been a similar percentage increase in commercial vehicle numbers (from 3,440 to 7,247) and a somewhat lesser growth for motor cycles (from 2,632 to 4,208).

There has only been a **17%** increase in population (from 51,458 at the 1971 Census to an estimated 60,268 in 1999) and a **35%** increase in households (from 16,446 in 1971 to 22,216 at the 1996 Census) during the same period. Our road carrying capacity remains essentially unchanged. Such an imbalance is clearly not sustainable.

Since around 20% of islanders who are legally entitled to own a motor vehicle do not currently do so, the potential for several thousand additional motor vehicles on our already overcrowded roads would undoubtedly have further detrimental affects on atmospheric, noise and visual pollution, and personal health on the islands.

Air quality monitoring

Commencing December 2000, the Environmental Health Department set up a site for"real time" air quality monitoring in the Grange, St. Peter Port to measure "roadside pollution levels" and in another two more distant sites to measure "background pollution levels".

Analysis of the initial data shows:

- there are clear peaks of pollution coinciding with both the morning and evening "rush hours";
- pollution levels during these peaks are approximately twice those on Saturdays, Sundays and Bank Holiday Mondays suggesting that the main contribution comes from commuter traffic;
- the peak levels in the Grange are approximately twice as high as those on the "background site" some two hundred metres distant;
- even at peak levels, limits are almost invariably within European minimum air quality standards;
- since the use of low sulphur fuels at the Power Station and the commissioning of the cable link with France, industrial emissions in Guernsey may be considered minimal; the main source of atmospheric pollution in Guernsey is undoubtedly motor vehicles working inefficiently in low gear on our overcrowded urban roads.

The relative successes of our participation in European *'Car-free'* Day (22nd September 2000) and Guernsey's own first *'Car-free'* Day (25th May 2001) confirm that a sizeable minority of island residents share these concerns and are prepared to make personal lifestyle changes to secure an improved local environment.

Decisions taken in isolation (such as additional urban parking) will displace rather than solve the problem. Only an integrated and comprehensive transport strategy has the potential to persuade car owners to reduce car usage for some journeys such as short trips to local shops or daily commuting to Town.

Potential major chemical incident

It is important to recall that not all threats to the local environment are generated locally. On 30th October 2000, the Italian-registered chemical bulk carrier *'Ievoli Sun'* started taking water into her ballast tanks. Her crew were airlifted from the ship, and she was taken in tow by the French authorities, but foundered and sank close to the edge of the "Hurd Deep" approximately 12 nautical miles north-west of Alderney. On board she had a cargo comprising styrene with inhibitor (3998 tonnes), methyl ethyl ketone (1027 tonnes) and isopropol alcohol (IPA - 996 tonnes) as well as a larger quantity of unused fuel oil.

The event was initially viewed as a "maritime pollution incident", and therefore it was the responsibility of the Maritime and Coastguard Agency (MCA), the French co-ordinating centre, the Alderney authorities and Board of Administration to deal with the effects of potential coastal pollution.

However, as the hull settled on the sea bed, there was leakage of styrene from one of the tanks, and when the wind shifted from the south-west to north-west one week later the harbour authorities in Alderney and visiting representatives of the MCA reported that they could detect a distinct "styrene smell".

Possible threats to public health from styrene gas (a toxic chemical which can cause irritation of mucous membranes and respiratory symptoms in the very young, the elderly, and those with impaired respiratory systems) obviously required a rapid public health response.

We were fortunate that our own States Analyst was able to give initial advice and that further advice was readily offered by the Medical Toxicology Unit at the National Poisons Centre, Guy's and St. Thomas' Hospital. Together with the other instrumentalities involved, a contingency plan was agreed and "real-time" sampling for atmospheric styrene gas established at the Alderney Harbour Office. In the event, the escape of styrene gas was self-limiting, and the entire cargo has now been safely removed using a Remote Operating Vehicle (ROV) technique.

However, the event reaffirms the importance of having access to specialist and technical knowledge and being able to agree an appropriate level of response sufficient to safeguard population health amongst the range of other authorities involved. Our sincere thanks are due to the Medical Toxicology Unit and National Poisons Centre, as well as to the MCA, for their advice and support.

Is "climate change" occurring?

The dramatic pictures of widespread flooding in York, parts of the West Country and along the south coast of England received widespread national television coverage. The National Weather Centre at Bracknell Berkshire has reported that the twelve-month period from April 2000 until March 2001 has been the wettest year since records began in 1766.

It was also the wettest autumn on record and the wettest April on record. Averaged across England and Wales, a total of 1299 mm of rain had fallen during this period.

The pattern in Guernsey was not quite so dramatic, although the Guernsey Meteorological Observatory did record *"the second wettest year on record"* at the airport in their year 2000 Annual Weather Report.

At the same time, the World Meteorological Organisation in Geneva has confirmed that the global mean temperatures for 1990, 1995, 1997, 1998 and 1999 were the highest since records began 140 years ago. The warmest years on record since 1860 have all occurred since 1983, and eight of the top ten have occurred since 1990. In all, global mean temperature was 0.32° Centigrade above the 1961-1990 normal.

Their verdict? *"When we look at patterns of change, we increasingly believe that a large part of the recent warming is due to fossil fuel burning."*

Indicators of Sustainable Development

This chapter began by taking a global perspective on health and the environment and suggested that energy policies in the US (for example) may contribute to catastrophic floods in Bangladesh or the disappearance beneath rising sea levels of entire island republics in the Pacific. Whether we like it or not, our actions as an independent and comparatively affluent jurisdiction will contribute (however minimally) to increasing global environmental pressures.

So how does Guernsey compare environmentally? An honest answer would have to be *"we don't really know"*, and if *"you can't manage what you can't measure"* then some sort of international environmental comparator for Guernsey becomes a necessity.

In 1987, the World Commission on Environment and Development (WCED) more commonly known as the "Brundtland Commission" after its Chairman, the then Norwegian Prime Minister Gro Harlem Brundtland (currently Director General of the World Health Organisation), proposed and popularised the phrase *"sustainable development"*.

"Sustainable development" was then defined as *"development that meets the needs of the present without compromising the ability of future generations to meet their own needs"*.

Five years after Brundtland, the United Nations Conference on the Environment and Development (the "Rio" Earth Summit) was held with 178 nations being represented and over 120 government leaders attending. Its achievements are summarised in the '27 *principles of the Rio Declaration'*.

However, it also became clear that such aspirations would remain empty rhetoric unless they were linked to measurable indicators and targets. Foremost amongst these was the need to develop acceptable and comparable *"indicators of sustainable development"* [ISDs].

Choosing local ISDs

Since *'Rio'*, many countries around the world have adopted and regularly report on their chosen lists of "ISDs". In the UK, *'Local Quality of Life Counts'*, published jointly by the Local Government Association, Department of the Environment Transport and Regions (DETR) and the "Improvement and Development Agency" in July 2000, proposed a menu of local indicators of sustainable development to be achieved under "Local Agenda 21". These comprise a national core of 150 indicators, with 15 national headline indicators, whilst in our "sister island" of Jersey some 19 "core indicators" have now also been proposed.

In Guernsey, the Environmental Policy Working Group established by the Advisory and Finance Committee held a half-day workshop in March 2001 with presentations from both the DETR in England and the Environmental Advisor to the States of Jersey.

From this, representatives of leading States committees, the private sector and community groups were able to select a "short list" of possible headline ISDs suitable for use in Guernsey.

It is pleasing to report that this concept has now been further accepted by the Advisory and Finance Committee, and that this proposed short list is included in the 2001 *'Policy and Resource Planning Report'* published in July 2001.

In the future, it is hoped that the annual reporting of our *"environmental accounts"* will be seen as equally important as economic indicators, such as gross domestic product or retail price index or social indicators such as unemployment levels or numbers of new houses built.

With this new information, for the first time we will be able to identify with greater certainty those environmental areas which we are managing well and those where we compare poorly with other jurisdictions and clearly need to improve our performance.

The "Harwood Report" and more "joined-up" government

This brief review of the inter-relationships between environmental factors and population health in Guernsey confirms that many areas of importance have been identified, and that most of these are now being addressed.

However, it also shows that in several areas (housing, liquid waste management, traffic strategy and adoption of *"indicators of sustainable development"* being the most obvious) the necessary progress has been unacceptably slow. Like trying to run up a descending escalator, it is possible to expend energy apparently moving forward and yet still to end up further behind.

As the rest of the world identifies and begins to address important environmental issues, Guernsey risks being seen as something of a "laggard" in its failure to implement the necessary counter-measures.

In response to the memorandum from the States Advisory and Finance Committee offering individuals the opportunity to make submissions to the *"Review of the Machinery of Government in Guernsey"*, the Director of Public Health summarised areas where he felt our present structures and processes may impact adversely on public health.

It was pointed out that, since the first English Public Health Act of 1848, it had become increasingly accepted that protecting and maintaining the health of the population is a central function of government. To achieve this requires an integrated approach across many areas of governmental activity, *e.g.*, environment, housing, transport, employment, *etc.* The effectiveness of government in Guernsey in this context needs to be judged by how well it can work across organisational boundaries to achieve measures which protect and improve public health.

Good government is about the ability to make difficult and sometimes unpopular decisions in the interests of the greater long-term public good.

In this context, it would seem that government in Guernsey has evolved with a series of checks and balances which all but prevent complex issues being addressed or major decisions being made. In particular, it was felt that:

- there does not appear to be any clear strategic direction or priorities, or if there are these are rarely translated into positive action;
- decision making appears costly, time consuming, repetitive and often inconsistent;
- decisions which are deemed to be potentially unpopular in the short term tend to be avoided even if they may lead to a greater long term good.

The changes proposed in the Harwood Report and the subsequent *'Statement of Views of the Panel', viz.* fewer politicians, fewer but larger States committees taking a more strategic view, more effective decision making and greater accountability by individuals for the decisions made, would seem to address many of these perceived shortcomings.

In the several important areas summarised in this chapter, health and the environment in Guernsey can only benefit as a result. The challenge must now be to ensure that this opportunity is not wasted, and that the necessary changes are made to our machinery of Government in the interests of protecting and improving our own local environment, our quality of life and health and our responsibilities to the wider world community.

Dr David Jeffs
Director of Public Health
October 2001

Chapter Two

Further Improving Health

Health needs and health services

In their latest formulation for global health improvement *'Health for all in the 21st Century'* (1998), the World Health Organisation (WHO) has pointed out that the most expensive way to provide health services is to wait until individuals fall sick and then attempt to "cure" their illness. The WHO suggests that an alternative is a model based on:

- a robust epidemiological analysis of the most common local diseases, most common causes of premature death and major areas of healthcare expenditure;
- a review of programmes for which there is sound "evidence" of success in preventing or reducing the health impact of such diseases;
- implementation of such programmes at the lowest possible "tier" of the health system, *i.e.,* in community and primary care in preference to secondary or tertiary care.

The more successful a health service is in moving down this gradient from "individual treatment" to "population/prevention" the more cost-effective that health system is likely to be.

In June 2000, the Board of Health published *"Our Healthier Islands",* a five-year review of local health between 1994 and 1999 particularly comparing population health indices around the 1991 Census (1988-1993) with those around the 1996 Census (1994-1998).

"Our Healthier Islands" suggested that this updated health information should be used *to* review health promotion priorities. It was pointed out that changing epidemiology, changing demography and changing expectations of health amongst the Guernsey population, together with changes in health technology, meant there might well be real changes in the "health needs" of the population and in the best ways of meeting these needs.

Selecting health promotion priorities

Several years ago when the NHS was faced with severe financial problems, work had been undertaken using focus groups to advise on possible "health rationing". Groups of medical practitioners, health managers and the general public had been asked to rank various health interventions - very different priorities were recommended by these various groups.

For this reason it was decided to widen the consultation exercise in Guernsey to include not only medical practitioners and Board of Health members and employees, but officers of other States committees, voluntary and community groups, representatives of business and industry and representatives of the local media who had particular insights into local opinion.

Table 2.1 Proposed Health Promotion Priorities January 2001 – December 2005

Tackling Health Inequalities

Health - 'Your Choice' – Priorities	First Round Score	First Round Rank	'Weighted' Second Round	Total Score	Final Ranking
'Lead' Priorities					
Discouraging and reducing smoking	210	(1)	132	342	1
Better preventing heart disease	212	(2)	217	429	2
Preventing and treating 'alcohol abuse'	290	(3)	165	455	3
Better preventing and treating bowel cancer	320	(4)	253	573	4
Tackling increasing overweight, poor exercise levels	400	(9)	285	685	5
Dealing with mental and social problems amongst youth	460	(12)	248	708	6
'Support' Priorities					
Discouraging and treating drug abuse	378	(6)	380	758	7
Promoting sexual health, etc	389	(8)	403	792	8
Reducing accidents and injuries amongst children	469	(13)	515	984	9
Better diagnosing and managing osteoporosis	461	(12)	563	1024	10
Cardiac rehabilitation	480	(15)	568	1048	11
Better managing stress	545	(16)	514	1059	12
To await appointment of third Health Promotion Officer					
Improving breast cancer prevention	353	(5)	515	868	13
Preventing, diagnosing and treating skin cancer	379	(7)	494	873	14
Improving cervical cancer prevention	407	(10)	480	887	15
Promoting prostate and testicular cancer on current 'best evidence'					15+
(Prevention and detection of less common cancers)	Not considered in Focus Groups				15+
Perceived lesser importance					
Increasing health literacy	478	(14)	590	1068	16
Better diagnosing and managing asthma	581	(18)	580	1161	17
Better diagnosing and managing diabetes	559	(17)	616	1175	18
Encouraging breastfeeding	649	(19)	711	1360	19
Reducing preventable suicides	650	(20)	713	1363	20

Two different "focus groups" were arranged, and participants were initially asked to rank 21 potential health promotion priority areas on the basis that these were:

- a common cause of premature death or disability
- an area of high health service expenditure
- an area where there was a perception that present services could be improved.

The 21 selected areas together comprised around 90% of all causes of premature death and correspondingly high areas of health service expenditure in Guernsey.

Around **65** local "opinion leaders" were initially identified as potential participants, of whom **49** (75%) returned their "first round" initial rankings. Of these, **38** (59%) were able to attend one or other of the two "focus group" sessions.

The Director of Public Health reviewed the "evidence" in *"Our Healthier Islands"* and participants then split into two main groups. Initially they were sub-divided into pairs, before coming together as foursomes, then as eightsomes, etc. to amalgamate and consolidate views as to the relative importance of the various health areas and interventions identified.

This was seen as a *"reality check"* - unless health promotion priorities are understood and supported by a wide cross-section of the community, a lot of health promotion effort is going to be wasted on areas not perceived as important by "opinion leaders" or the public more generally.

In the event, there seemed to be a high level of agreement as to where we should be focusing our fairly limited health promotion resources over the next five years - as summarised in **Table 2.1.**

Further discussion has suggested that *"tackling health inequalities"* could best be dealt with as an "umbrella" across all programmes - *e.g.,* initiatives to *"improve nutrition"* or *"promote exercise levels"* would be preferentially targeted at those most likely to benefit often the least affluent members of our community.

Health trends in 2001

As well as identifying "health promotion priorities", it is important to be able to demonstrate ongoing improvements to population health in these selected areas. As summarised in **Figure 2.1** cancers, circulatory diseases and accidents and injuries (including suicides) are responsible for over 2,250 *"potential years of life lost"* (PYLL) (that is, premature deaths <75 years) every year in Guernsey.

These represent over 80% of all premature deaths in Guernsey and have therefore been selected for annual reporting. The use of "three-year rolling averages" have again been used to "iron out" large year-to-year variations.

Figure 2.1 - 'Potential Years of Life Lost' (PYLL)

Trends: 1988/93 and 1994/98 compared

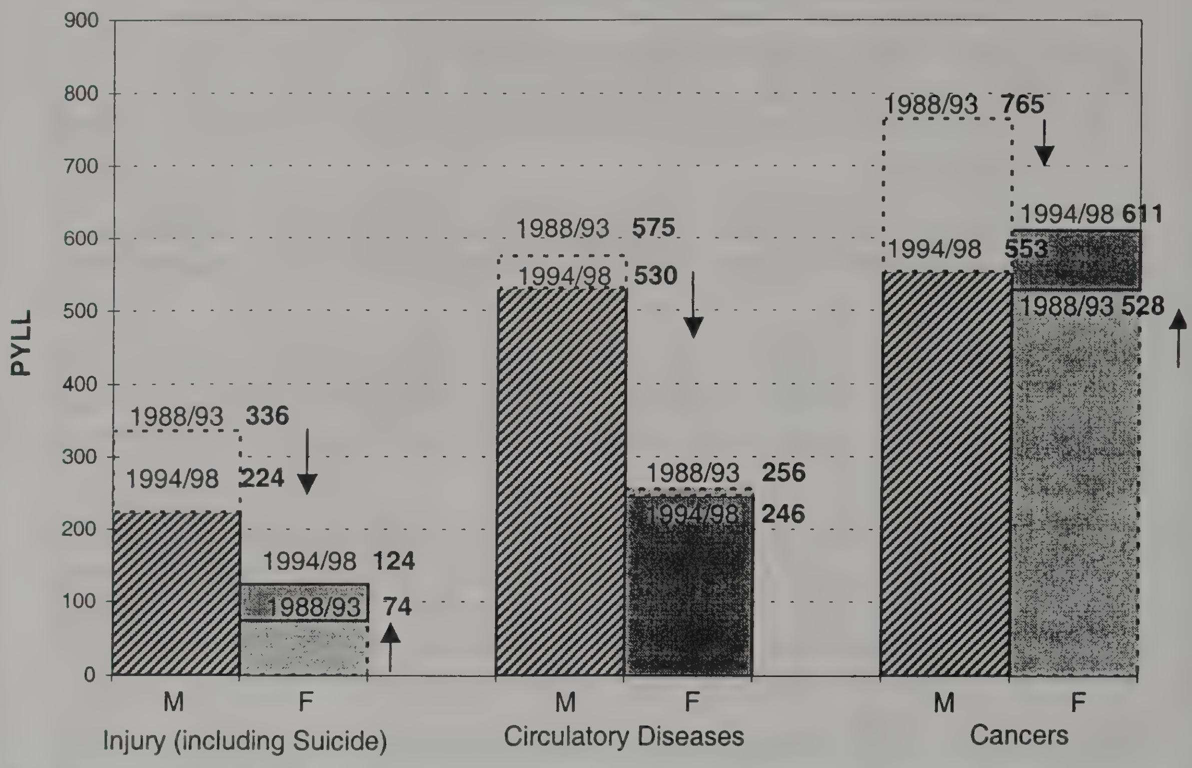
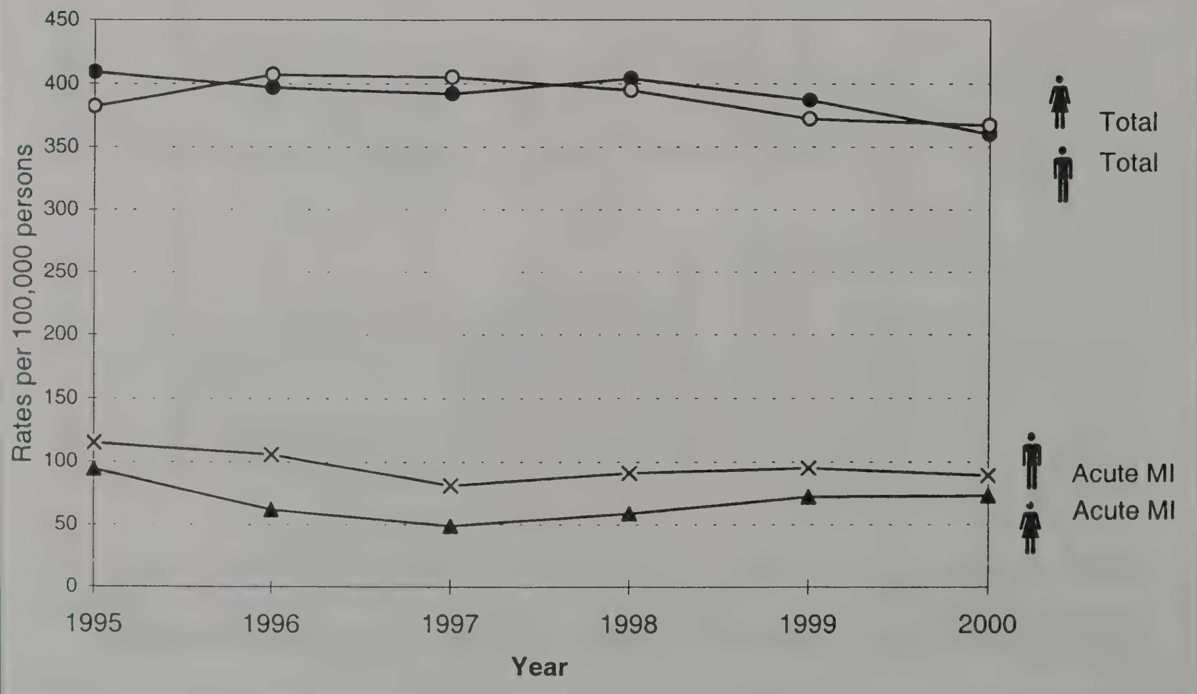


Figure 2.2 - Acute and Total Cardiovascular Mortality 3 Year Rolling Averages - Guernsey 1993-2000

Males and Females : rates per 100,000



- **Cardiovascular mortality (Figure 2.2)**

Male deaths from acute myocardial infarction, and male deaths from all cardiovascular causes have continued the downward trend seen over the past several years. In contrast, the rising trend in female deaths from acute myocardial infarction continues, and there is now little difference between male and female mortality rates from all cardiovascular causes.

- **Cancers (Figure 2.3 - 2.5)**

A similar picture is seen in total cancer mortality with a continuing fall in male deaths (in part due to continuing falls in lung cancer deaths) and a slight rise in female lung cancer and breast cancer (though not in large bowel cancer) leading to an overall increase in female total cancer mortality.

The slight downward trend amongst both men and women for large bowel cancer mortality seen in the past few years seems to be continuing.

- **Total injury and suicide mortality (Figure 2.6)**

There has been a continuing fall in male suicide deaths, contributing to the continuing decline in injury (both intentional and non-intentional) deaths seen amongst Guernsey males, and a falling level of suicides, but a plateauing of “all injury mortality” amongst Guernsey females.

Progress with “clinical indicators”

Annual mortality figures are a fairly blunt instrument for measuring the burden of any particular disease or condition in the population and the effectiveness of the various health interventions to try and ameliorate this. Accordingly, there has been increasing interest in “clinical indicators” to measure the quantity, quality and effectiveness of the various health interventions provided.

In the NHS, hospital activity data, such as admissions, average length of stay, bed occupancy, *etc.*, have been available for many years. More recently, outpatient data such as waiting times, “failure to attend” levels, *etc.*, have also been collected.

In parallel, a *‘Public Health Common Data Set’* has been gradually expanded and refined. As well as traditional mortality statistics, this now contains details of cancers, maternal and child health (including congenital malformations), infectious diseases, mental and oral health, *etc.*, all reported on an individual Health Authority basis.

More recently, the publication of the *‘Performance Assessment Framework’* in July 2000 and a Consultation Document on *‘NHS performance indicators’* in May 2001 have sought to integrate health data from various sources to produce a group of indicators, which will reflect overall Health Service performance.

Within the NHS it is hoped that such performance measures will prove useful to:

- inform patients and the public;
- set targets and track progress over time;
- compare performance between health units;
- allocate resources.

Figure 2.3 - Total Cancer and Lung Cancer Mortality
3 Year Rolling Averages - Guernsey 1993-2000
Males and Females : rates per 100,000

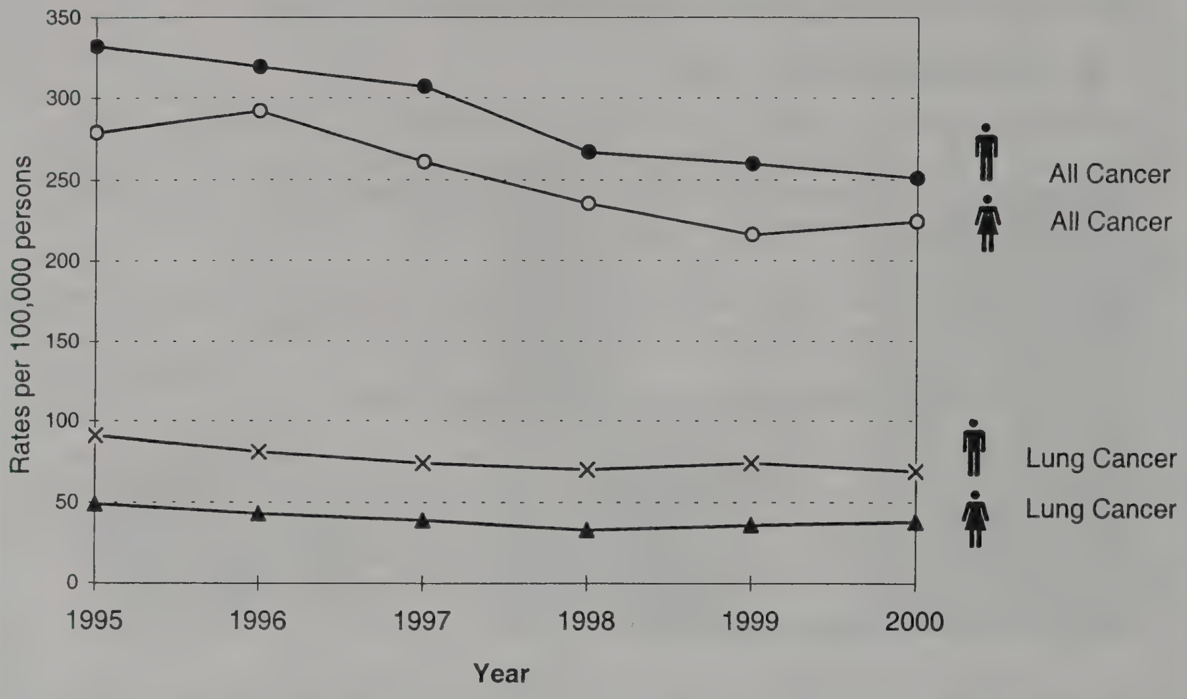


Figure 2.4 - Total Cancer & Large Bowel Cancer Mortality
3 Year Rolling Averages - Guernsey 1993-2000
Males and Females : rates per 100,000

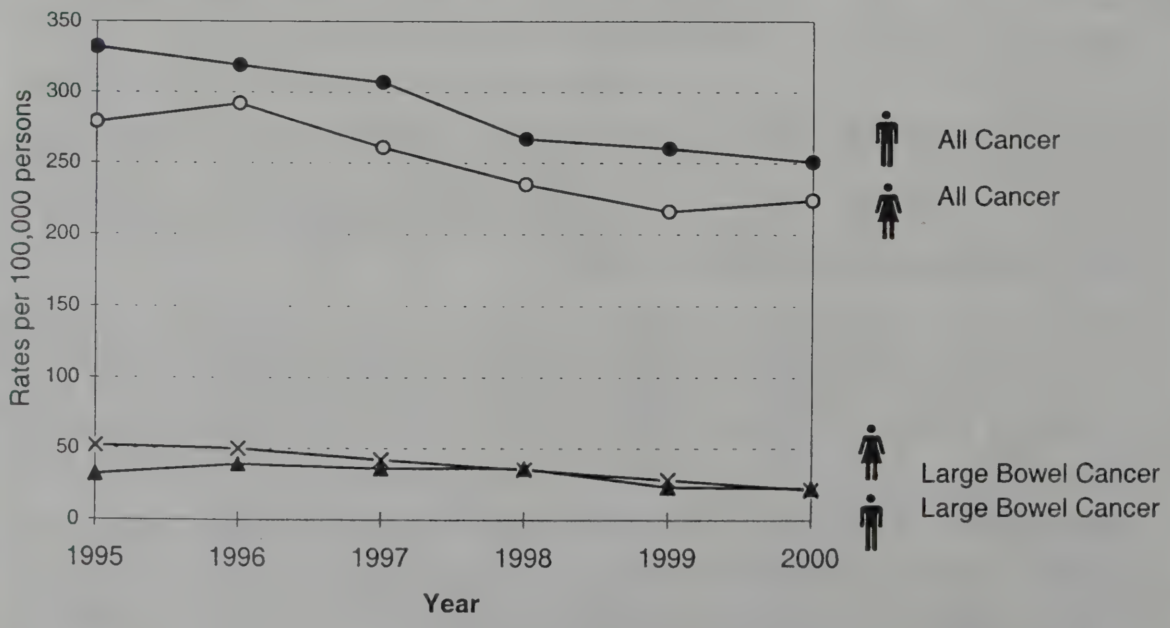


Figure 2.5 - Total Cancer and Breast Cancer Mortality 3 Year Rolling Averages - Guernsey 1993-2000

Males and Females : rates per 100,000

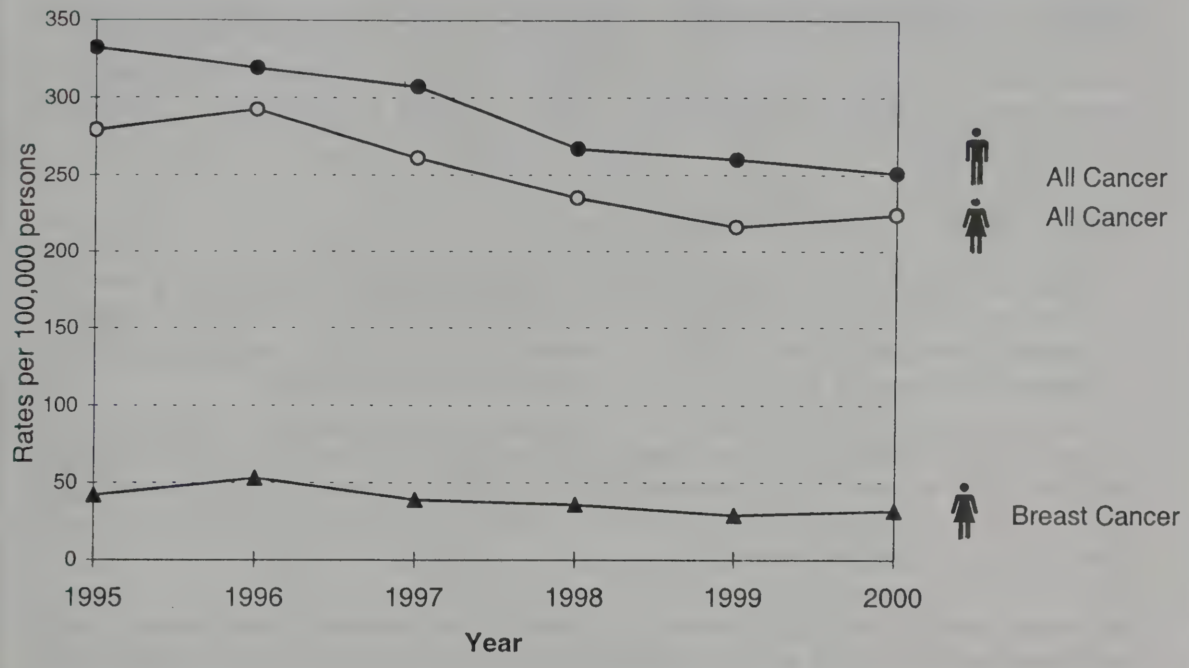
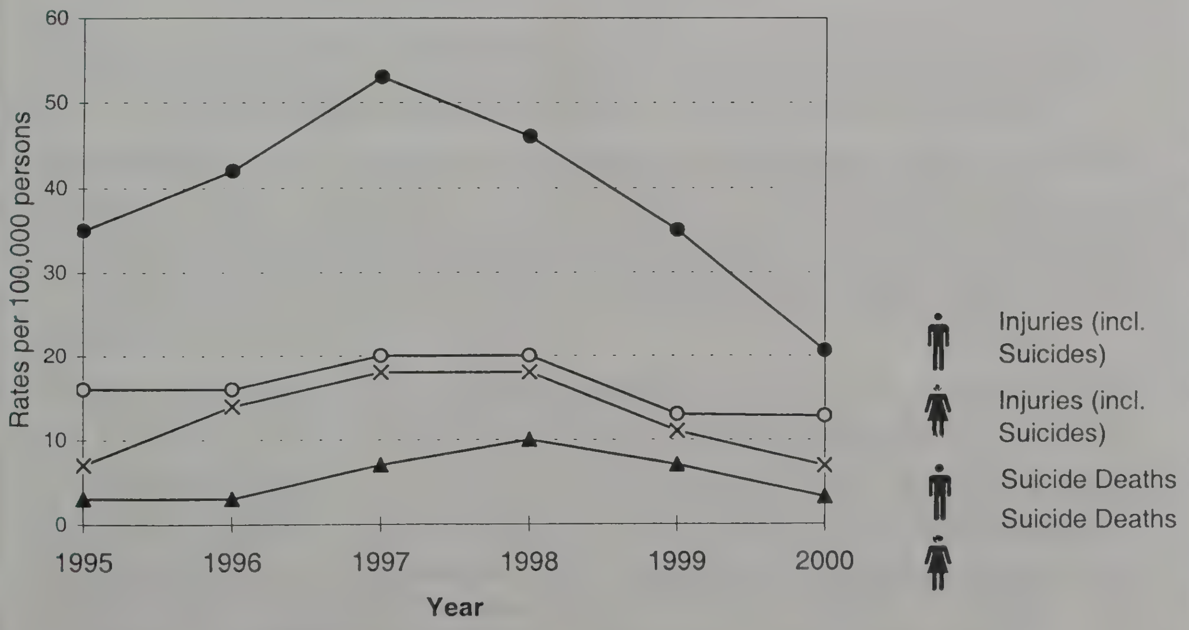


Figure 2.6 - Total Injury and Suicide Mortality 3 Year Rolling Averages - Guernsey 1993-2000

Males and Females : rates per 100,000



The full list is very comprehensive, and includes coronary heart disease, cancers, mental health, diabetes, sexual health, teenage pregnancy, smoking levels *etc.* - in all, some 25 aspects of overall performance.

Once results are available on a Health Authority or NHS Trust basis, it is inevitable that the Board of Health will be asked how services in Guernsey compare with published data from the UK. It is therefore important that we are able to identify a limited selection of such indicators covering a representative range of conditions so that we can at least have a meaningful comparator. It is hoped to identify and report on such a "short list" within the next 12 months.

Clinical governance in Guernsey

"Clinical governance" is an umbrella term for all those activities which result in the delivery of high quality clinical services and excellence in health outcomes. Promoting good *"clinical governance"* should be an accepted and a demonstrable part of the work of all health care professionals.

"Clinical governance" was proposed in the NHS White Paper *"The NHS: Modern, Dependable."* (December 1997). All NHS Trusts were required to have structures in place for achieving *"clinical governance"* by the end of 1998.

Not being part of the NHS, there is obviously no statutory requirement for the Board of Health to adopt similar measures. However, reports of recent "medical mishaps" in the national media, the support by the various *'Royal Colleges'* that high standards of clinical care are not only practised but can also be demonstrated and impending moves towards medical revalidation by the General Medical Council (GMC) all mandate that parallel structures to ensure good *"clinical governance"* are adopted in Guernsey.

The Board of Health has agreed to support such developments and the basic structures are already in place:

- Clinical audit/clinical risk management activities have been established across all major specialities, and the Medical Specialist Group have implemented a series of *"academic half-days"*.
- A start has been made on establishing separate clinical audit/clinical risk management groups in mental health and elderly care services.
- The Chairmen of the three primary practice groups have agreed to support the introduction of *"clinical governance"*, but are concerned about its effect on work load and the primary care "manpower formula".
- Both medical practices in Alderney have agreed to support appropriate *"clinical governance"* activities.
- A Clinical Risk Manager and a Clinical Audit Nurse have been appointed.
- It has been agreed by all parties that the Medical Advisory Committee (MAC) should act as the "final common pathway" for reporting *"clinical governance"* activities to the Board of Health.

However, despite this progress, services in Guernsey must be seen as lagging behind their counterparts in the UK in addressing *"clinical governance"* issues. In particular:

- Clinical audit "activities" often address areas of interest rather than areas of importance with respect to the population health of Guernsey

- Little attempt has been made to date to audit "evidence based" practice across the clinical services provided

- There has been no general agreement about reporting mechanisms below the Board of Healths Medical Advisory Committee, and there has been no single individual charged with ensuring that good *"clinical governance"* can be demonstrated. In many NHS Trusts, this would be the responsibility of the Medical Director or in some a specially appointed Director of Clinical Governance.

Local research ethics committee

One result of the increasing interest in "evidence-based" practice and the need for local health data has been the increasing amount of health research undertaken locally.

In accordance with recommended practice, a local medical research Ethics Committee established some years ago to ensure that high ethical standards are maintained in the conduct of all clinical research investigations undertaken locally. The local committee contains both medical and lay members and during 2000 considered 5 applications to conduct local medical research.

A number of additional applications were also vetted by the Director of Public Health and the then Chief Nursing Advisor, but were felt not to require Ethics Committee approval because they did not involve experimentation on human subjects and/or used only anonymised patient data. Such studies may more correctly be viewed as "clinical audit".

Local research of particular interest includes:

- **Medicinal use of cannabinoids**

Chronic neurogenic pain, muscle spacicity associated with multiple sclerosis (MS), pain associated with rheumatoid arthritis (RA) and less common conditions such as trigeminal neuralgia tend to be resistant to conventional medical treatments. There has therefore been increasing interest over recent years in using extracts from the cannabis plant (cannabinoids) to treat aspects of these conditions.

The Board of Health agreed in February 2000 that such trials could take place on Board of Health premises, and following approval of the trial protocol by the medical Ethics Committee, a medical research centre was established and a medically qualified research co-ordinator appointed. Some 50 people were referred to the centre, of whom 30 were screened and 21 were selected in that they fulfilled the full "entry criteria" for the trial. Approximately half had MS, 4 had RA and the remainder a range of neurological conditions with intractable symptomatology.

The research design was of an "N of 1" "double-blind" cross-over trial, in that neither the researcher nor the patient was aware at any particular time whether the active constituent or a placebo was being used. Preliminary results suggest that the great majority of those patients with MS and RA have both found benefits over and above those obtained from their current medication or the placebo and have now entered into the "long-term extension" phase of the trial.

The trial will be continuing in Guernsey, and it is hoped to recruit at least a dozen new patients during late 2001/2002.

- **Bupropion as an aid to smoking cessation**

In the recent White Paper *"Our Healthier Nation" (1999)*, smoking is described as *"the single greatest cause of avoidable illness and preventable deaths in this country ... smoking is the most powerful factor which determines whether people live beyond middle age"*.

This view is endorsed in the Board of Health publication *'Our Healthier Islands' (2000)*, and preventing smoking uptake/promoting smoking cessation was accordingly identified as the leading health promotion priority in the *'Health - your choice'* exercise referred to above. There was therefore intense interest in the new smoking cessation drug *bupropion* (Zyban) which is believed to act centrally on the "satiety centre" to assist smoking cessation.

The drug received its product licence in September 2000, and the Prescribing Support Unit Steering Group established between the Guernsey Social Security Authority and the Board of Health in 1998 agreed that up to eight weeks' treatment could be prescribed at normal prescription charges providing that the recipient attended the motivational support workshops run by the *'Guernsey Quitline'*.

After a four-month "shakedown period" all participants enrolling in the course from January 2001 were formally entered into a trial to evaluate the effectiveness of the combined approach.

Early results suggest that **65%** of smokers who enrolled in January 2001 and attended the complete eight-week course of motivational support were still not smoking a full three months later.

These figures compare very favourably with only **5%** of smokers succeeding in quitting without outside help and the 15%-30% success rates reported from most UK programmes.

It is intended to publish a formal evaluation of outcomes for all those who enrolled in January-June 2001 in due course.

Chapter Three

Environmental Health

2000 Overview

With the retirement of Mr Mike Bairds in December 1999 and the appointment of Mr John Cook and Mr Tony Rowe as Chief and Deputy Chief Environmental Health Officers respectively, a vacancy arose for an Environmental Health Officer within the department. The vacancy proved difficult to fill, and Ms Isobelle Belcher did not take up her appointment as Environmental Health Officer on a short-term contract until August 2000. In the meantime Mr Jonathan Coyde, who had been with the department since 1996, decided in the middle of the year to explore foreign climes. This resulted in the department being one Environmental Health Officer short for the whole of 2000 and two officers short during two months of the busy summer period. Fortunately the department was able to employ a student, Miss Emily Browning, during July and August, and she carried out the majority of the routine swimming pool sampling and a food temperature survey.

The Trainee Environmental Health Officer continued to progress with his MSc studies at Birmingham University and is expected to graduate and be accepted as a Graduate Member of the Chartered Institute of Environmental Health early in 2001.

The Chief Environmental Health Officer, Deputy Chief Environmental Health Officer and Waste Regulation Officer were all actively involved in the implementation and regulation of the States' Solid Waste Strategy; the Chief Environmental Health Officer being a member of the Solid Waste Working Party and the Deputy Chief Environmental Health Officer a member of the Project Team.

The Department's waste regulation and environmental protection roles were somewhat frustrated during 2000 when the UK Home Office required the amendment of the *'Transfrontier Shipment of Waste Ordinance, 1999'* in order to achieve Basel Convention compliance, and the proposed *'Control of Environmental Pollution'* legislation was not implemented. An outside consultant, Dr G.W. Rae was commissioned to assist in the preparation of the *Projet de Loi* for the *'Control of Environmental Pollution (Guernsey)'* legislation.

Visits by Department Staff

The department is organised into two main sections - Food Safety and Infection Control, which deals with the inspection of food premises, food hygiene training and investigation of infectious diseases, and Environmental Control, which deals with matters such as housing, noise and air pollution. This section also deals with rodent control and employs two rodent control operatives. The department also carries out waste regulation and employs a waste regulation officer. The department completed a total of 6460 visits during 2000, and these are detailed under the section headings.

Figure 3.1 Food Safety and Infection Control

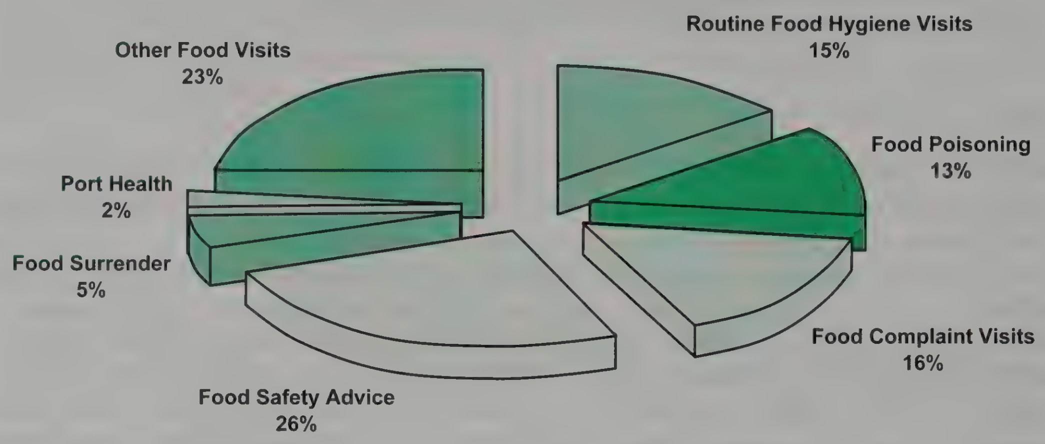


Figure 3.2 Food Complaints 2000 - 72 Complaints

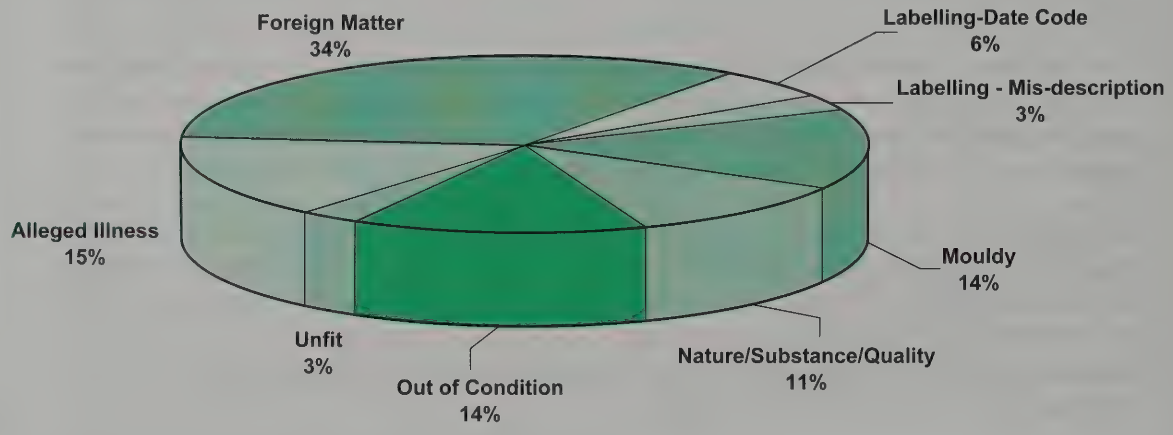
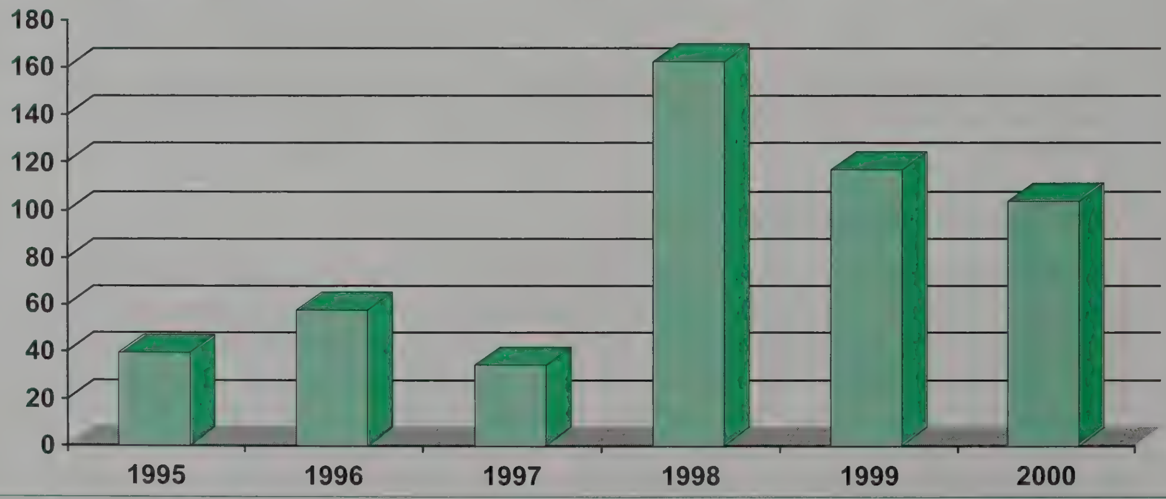


Figure 3.3 Basic Food Hygiene Certificate Training



Food Safety and Infection Control (Figure 3.1)

The department continued to promote its Hygiene Award Scheme in 2000, following its successful launch in 1998. The Award scheme recognises high standards in food hygiene and is divided into three parts - practice and structure, hazard analysis and staff training. In each area, emphasis is placed on complying with the legal requirements, recognising good practice and the demonstration of due diligence. Unfortunately, the take-up of the award by the trade was not as good as in previous years, and only 3 premises were granted the award during the year. Further efforts will be made to promote the award in 2001 when the department is again fully staffed.

The Food Safety section made 1997 visits during the year 2000. Of these 1059 were initial visits, with 938 being revisits.

● Food Complaints (Figure 3.2)

A total of 72 food complaints were received during the year, a slight increase over the 69 recorded in 1999.

42 of the complaints were either unsubstantiated or the source of the problem occurred subsequently to the purchase of the food. Only one of the complaints was referred for prosecution.

● Food Surrender

A total of 27 surrender certificates, including one issued in Alderney, were issued during the year. This compares to 26 issued in 1999. The Board's policy of charging for the issue of certificates, freeing valuable officer resources, continues to keep such requests to a minimum, and there has been a great reduction from the peak of over 200 in 1992.

● Food Hygiene Training (Figure 3.3)

The Board's Hygiene Award Scheme has continued to generate interest in the Basic Food Hygiene Certificate.

11 Basic Food Hygiene courses were run by the department in 2000. Of the 107 candidates, 104 successfully completed the course and were awarded the Certificate. Unfortunately, owing to a lack of staff resources, neither the Intermediate Certificate Course nor the Hazard Analysis Awareness Course was run this year. The department hopes to be able to run these courses again in 2001.

● Formal Action

Two Improvement Notices were served during the year. This involved two premises - both take-away food premises. One of the notices related to a rodent infestation, whilst the other concerned inadequate temperature control due to poor maintenance of refrigerators. Both Improvement Notices were complied with, without the need for prosecution.

One food complaint was referred for prosecution. This resulted in a formal Police caution for the company concerned.

Figure 3.4 Salmonella/Campylobacter Notifications 1994 - 2000

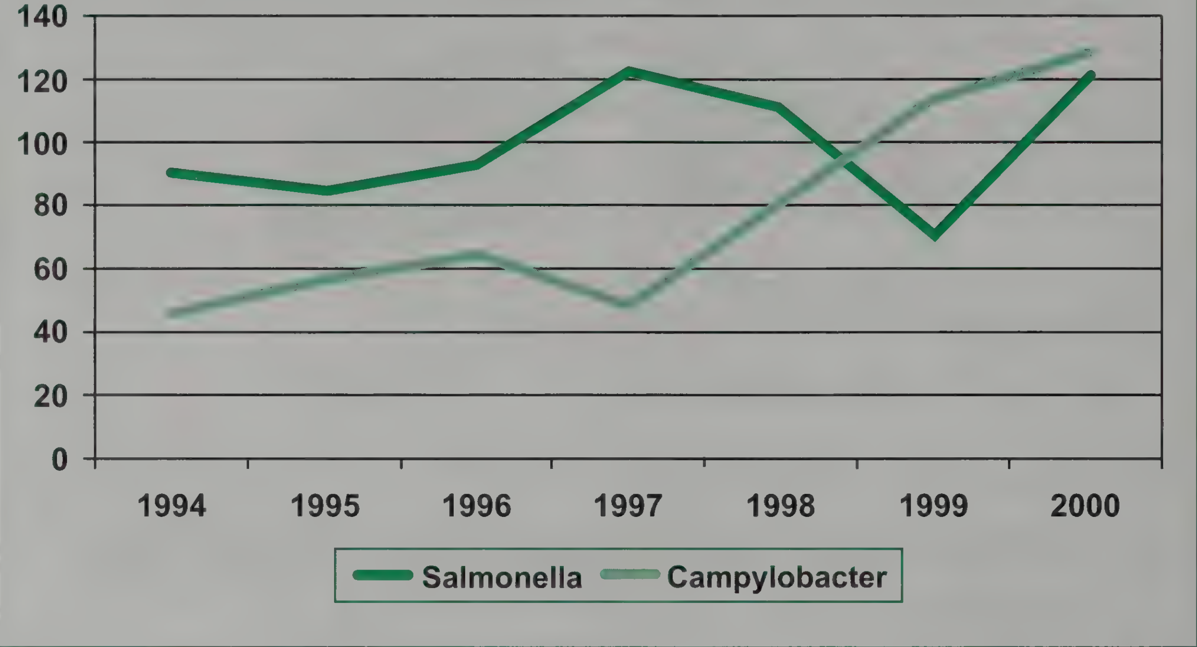
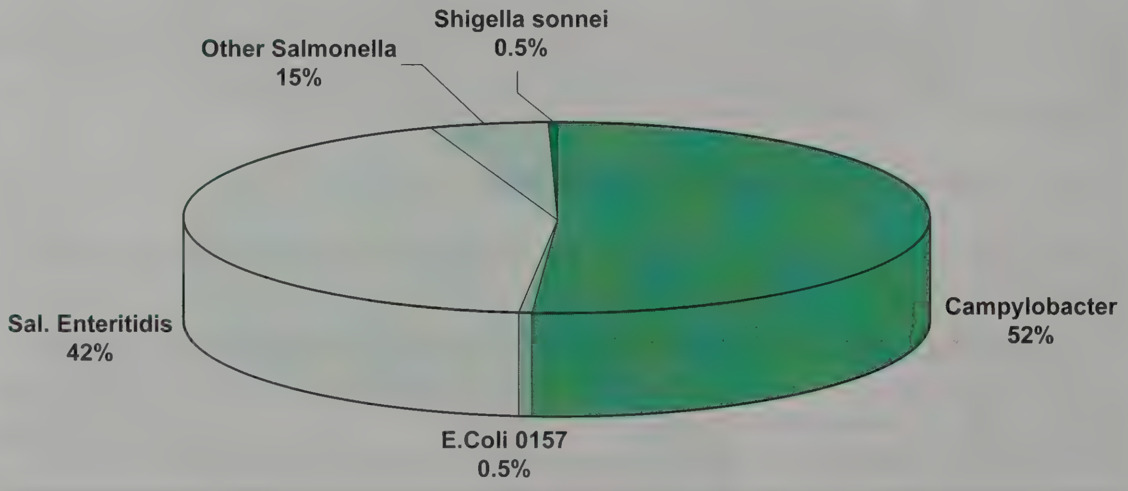


Figure 3.5 Food Poisoning 2000



- **Food Poisoning (Figures 3.4 and 3.5)**

A total of 118 confirmed cases of salmonella food poisoning were notified to the department during 2000. This figure reverses the recent downward trend and is the highest since 1997. There were two small outbreaks, one at a restaurant and the other at the King Edward VII Hospital. The rest were individual cases or family outbreaks, and 8 originated outside the Bailiwick. Raw or undercooked eggs were the foods most commonly indicated as the vehicle of infection. One case of *E.coli 0157* was notified to the department; this was contracted outside the island. Additionally, there were 126 confirmed cases of *campylobacter,* which reinforces the recent upward trend in notifications.

Environmental Control (Figure 3.6)

Officers made a total of 2123 visits during 2000. 996 were initial visits with the remainder (1127) being follow up visits.

- **Water Samples (Figure 3.7)**

The following samples were taken during 2000 for chemical and/or bacteriological analysis.

Water Samples 2000	
Swimming Pools	98
Wells	15
Boreholes	43
Mains Water	33
Sea Water	505
Leachate	135
Other Water Sources	1
Totals	830

Figure 3.7 compares the 2000 sampling programme with previous years' sampling.

- **Shellfish Sampling**

There are 9 graded shellfish beds around the island, although only 6 are in use. 4 are in grade A (the top grade) whilst the other 5 are in grade B. All shellfish are for local consumption. A total of 48 shellfish samples were taken during the year. From the results of these samples, 34 consignments were passed fit for human consumption whilst 14 remained for further purification.

- **Rodent and Pest Control**

1156 treatments were carried out including 63 disinfestations. Systematic treatments of bays and headlands have continued throughout 2000. Rodent control operatives carried out 2340 visits in total during the year.

Figure 3.6 - Environmental Control

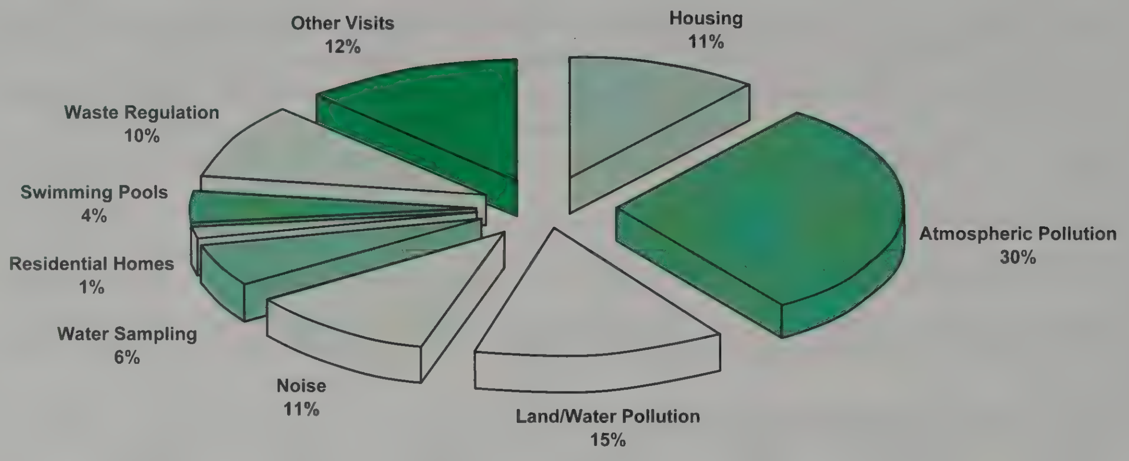
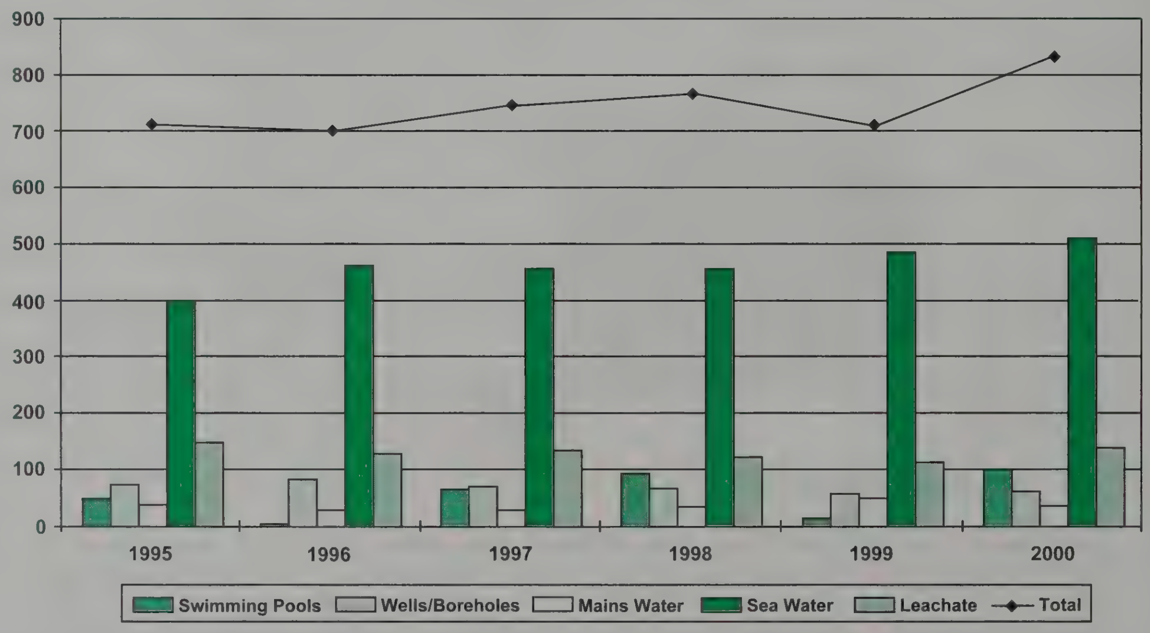


Figure 3.7 - Water Samples 1995-2000



- **Housing**

63 complaints were received during 2000. This resulted in 221 visits to premises to assess housing conditions and to ensure unsatisfactory conditions were remedied. Areas of concern included overcrowding, dampness and unsatisfactory living conditions. The vast majority of the complaints were dealt with by informal action with landlords, and it was only necessary to issue three closing notices in respect of units of accommodation unfit for human habitation.

- **Air Quality (Figures 3.8 - 3.13)**

The department's real-time air quality monitoring continued throughout 2000. Results indicate that the general air quality of Guernsey remains very good. No exceeding of the relevant guidelines was noted, and average levels of the measured pollutants were considerably below the guideline levels.

Nitrogen Dioxide (Roadside)

Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	81	8 November
WHO Health Guideline (24 Hour)	80	33	22 March

WHO = World Health Organisation

Nitrogen Dioxide (Background)

Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	53	10 January
WHO Health Guideline (24 Hour)	80	22	28 January

Sulphur Dioxide

Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	122	30	21 February
WHO Health Guideline (24 Hour)	100	37	21 February

EPAQS = Expert Panel on Air Quality Standards

Particulates (PM 10)

Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (24 Hour)	70	42	3 March and 7 May
EPAQS Guideline (24 Hour)	50	41	24 August

Graphs giving the annual results for the above pollutants can be seen at figures 3.8 to 3.11.

FIGURE 3.8 REPORT FOR 01/01/00 24:00 - 31/12/00 24:00; Nitrogen Dioxide
STATION: GuernseyB Roadside

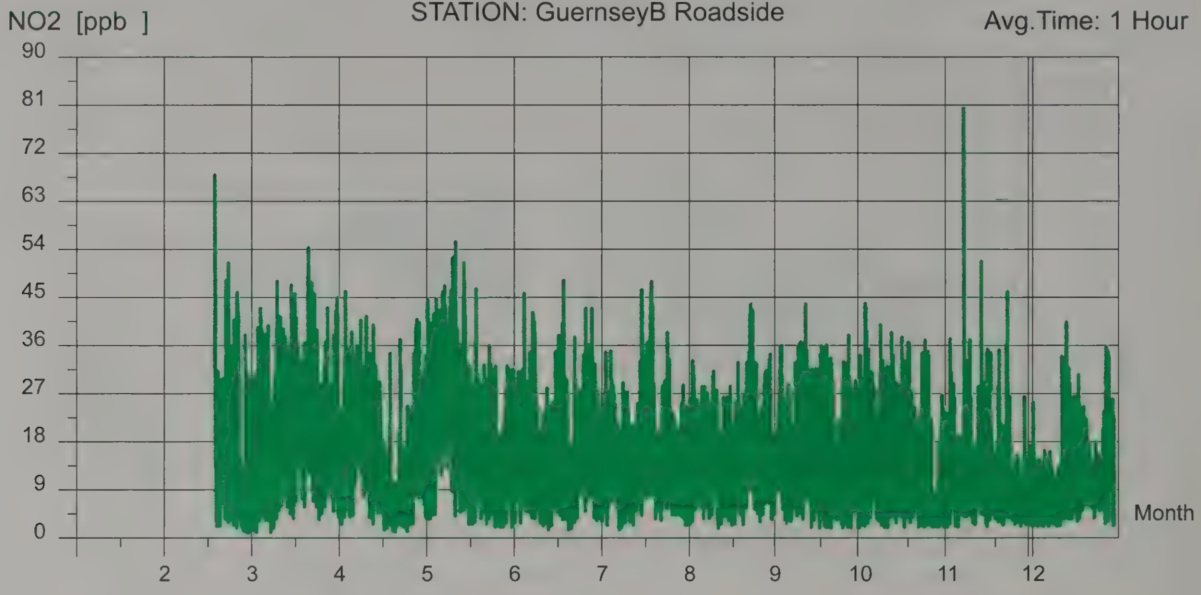


FIGURE 3.9 REPORT FOR 01/01/00 24:00 - 31/12/00 24:00; Nitrogen Dioxide
STATION: GuernseyA Roadside

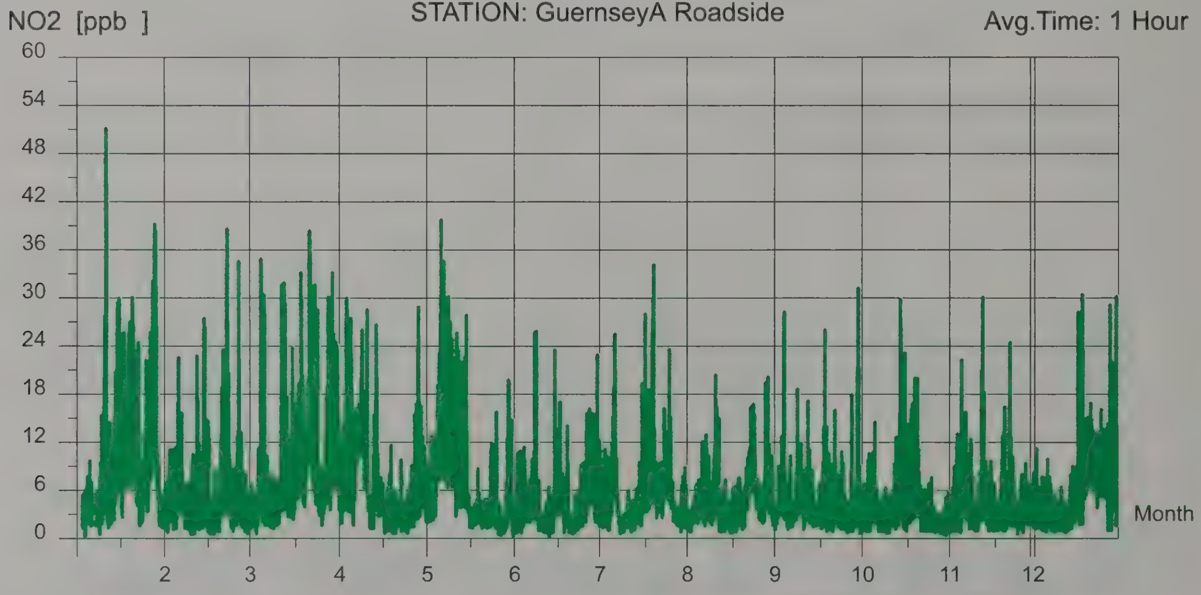


FIGURE 3.10 REPORT FOR 01/01/00 24:00 - 31/12/00 24:00; Sulphur Dioxide
STATION: GuernseyA Background

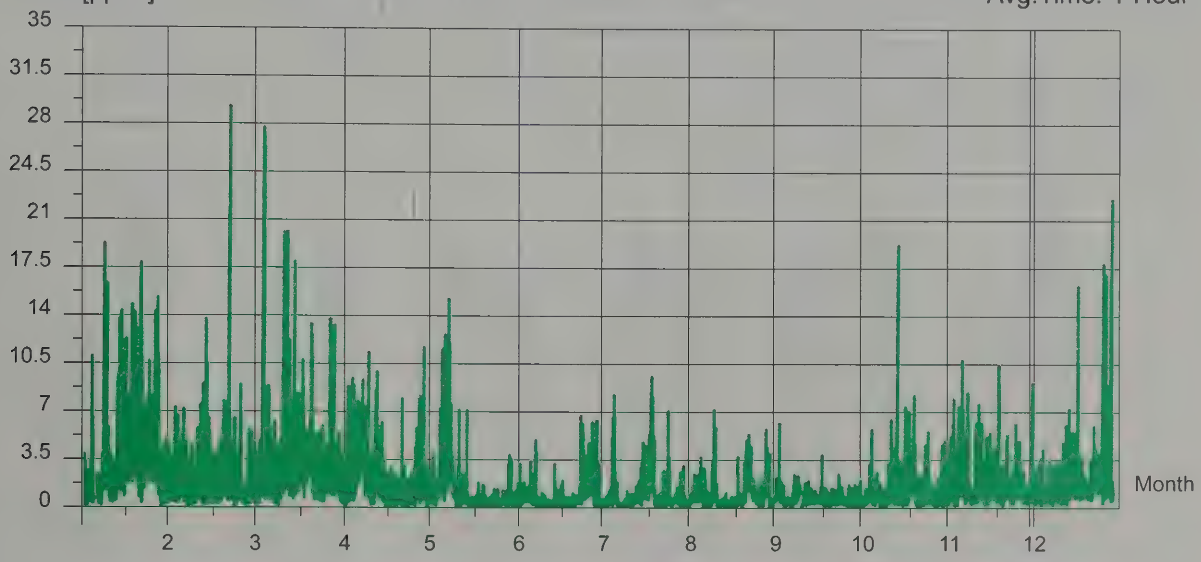


FIGURE 3.11 REPORT FOR 01/01/00 - 31/12/00; Particulates (PM10)
STATION: GuernseyA Background

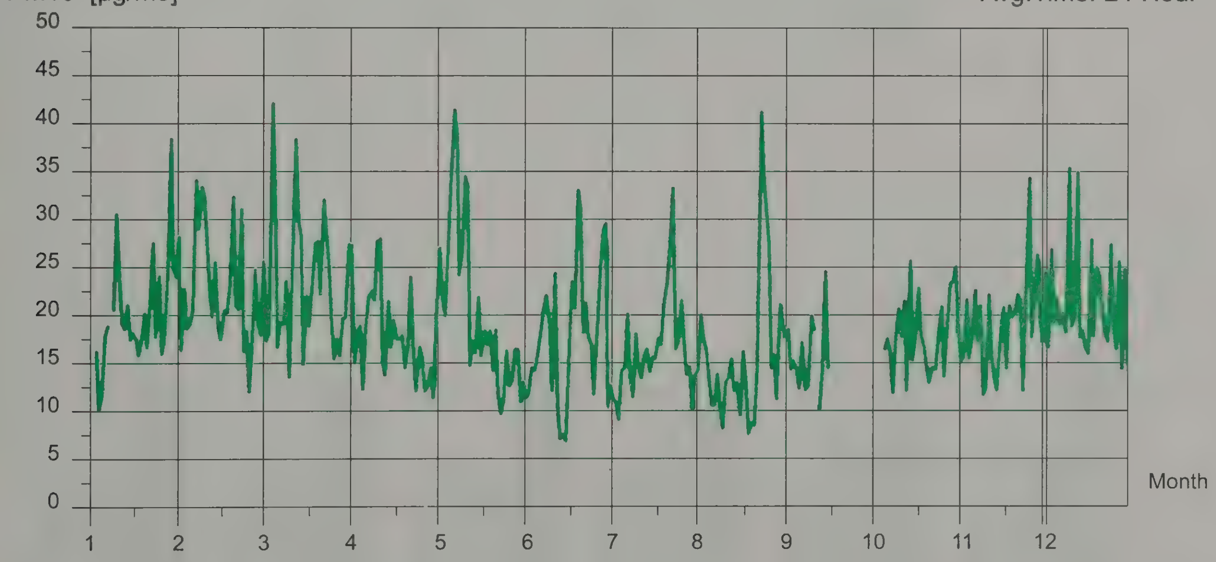


Figure 3.12 Nitrogen Dioxide Survey - Results in parts per billion (ppb) in St. Peter Port 1995 - 2000

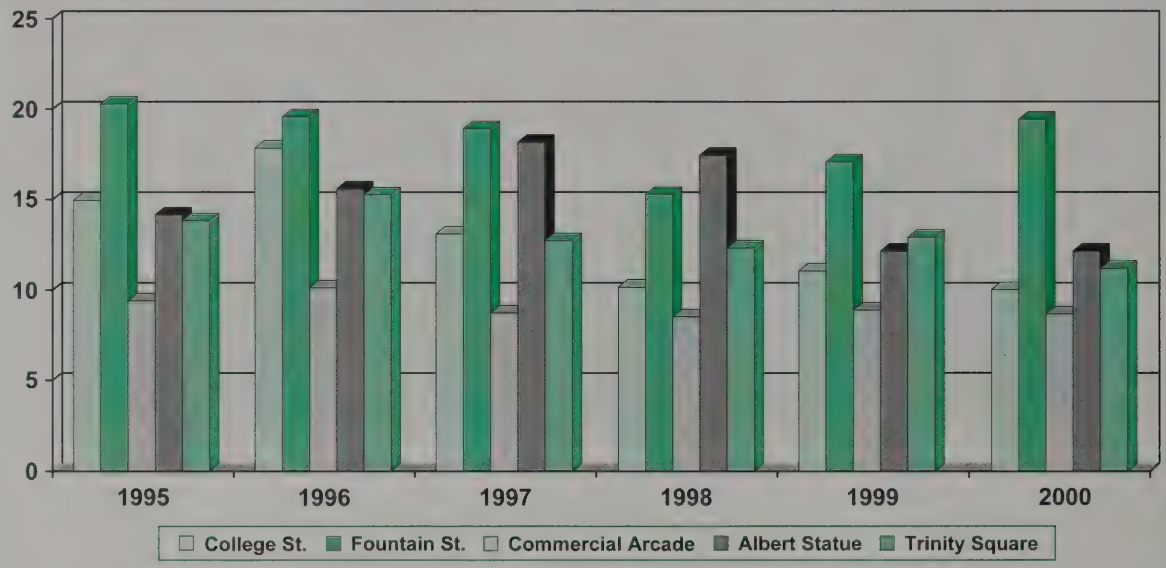
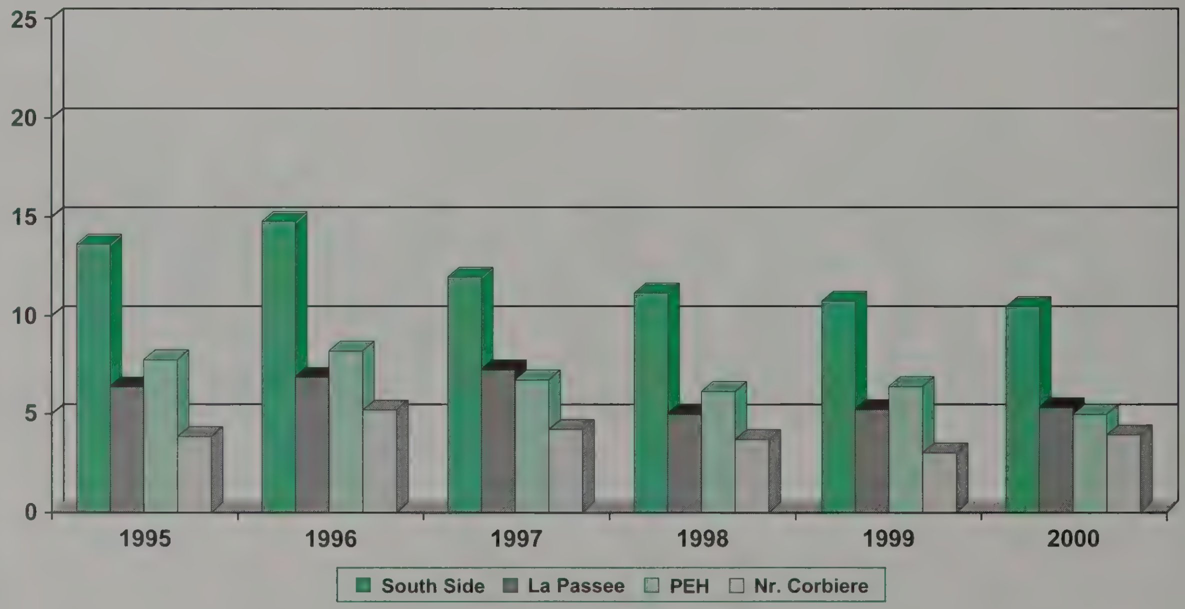


Figure 3.13 Nitrogen Dioxide Survey - Results in parts per billion (ppb) at other island sites 1995 - 2000



The department also continued its monthly nitrogen dioxide survey at nine sites around the island. The overall downward trend of previous years continued, although one of the St. Peter Port sites showed a small increase in levels compared to 1999.

The UK's Department of the Environment indicates that levels of nitrogen dioxide below 50 ppb indicate "Very Good" air quality. The results show that the standard of air quality in respect of nitrogen dioxide is well within recognised international standards.

Unfortunately, bonfires of all types continue to be a major cause of complaint to my department. Changes in the public health laws in 1999 made smoke from premises a statutory nuisance. Such bonfires are largely unnecessary as alternative, and in most cases more suitable means exist for disposing of waste.

Mr John Cook
Chief Environmental Health Officer

Bowl
727418
I'm with the Walking Bus!
I'm with the Walking Bus!
Circuit Skins

Chapter Four

Health Promotion Unit

Increasing "Awareness"

The past twelve months have once again proved to be very busy for the Health Promotion Unit. One aim, in addition to work in specific areas, was to increase clients' awareness of the services the Unit provides. This has been achieved through various initiatives including the creation of a website – www.guernseyhealthpromotion.com. From the initial launch in **September 2000,** the number of visits has steadily increased to an average of **400** hits per month including many from overseas. As well as outlining the services on offer, the website has pages which outline the latest campaigns, *e.g.*, osteoporosis, sun awareness and a page of links to other useful health-related sites.

In addition, displays on the work of the Unit have been set up at the Education Development Centre and at five different schools, and presentations have been given to NVQ and GNVQ students, nursing staff and secondary school pupils. Three editions of the Unit's newsletter *'Unit'* have been produced and sent out to over 700 different contacts, and the number of resources out on loan has increased from 1731 in 1999/2000 to 1871 in 2000/2001. In the same period, the number of leaflets distributed increased from 51,300 to 66,300.

Health Promotion in Action 2000/2001

*All pictures courtesy Guernsey Press except **

Assistant Health Promotion Officer, Gerry Grange and Peter Falla, Tourist Board examine the first edition of the Guide to Smoke free eating and drinking in the Channel Islands

Health Promotion Officer Yvonne Le Page launches 'Eat for Life' Month, October 2000 with the help of Guernsey Market Traders

Two pupils from Forest School take part in their Walking Bus as part of Walk to School Week, May 2001

New GASP staff Katherine Green and Joanne Staples promote their Aquathon, July 2000

Annette Henry, Quitline Advisor leads a smoking cessation group, September 2000

Smokebusters join Phil Le Bin for a cigarette end litter hunt, July 2000

*

One of the Walk your Way to health groups sets off June 2001
(photograph courtesy of Robin Millard)

'Live for Life'

The *'Live for Life'* healthy lifestyle programme continued with an emphasis on nutrition during *'Eat for Life'* month in September. *'Live for Life'* tutors also ran weight management courses, circuit training courses and a variety of sessions on stress management, healthy eating and cancer awareness. The health promotion officers led a number of different sessions for Specsavers staff and for a mental health support group and assisted in the production of a stress in retirement video which should be available in the autumn. The Cardiac Rehabilitation programme was revamped to include two tutors per session and has recently changed to a rolling programme so that waiting times for new clients are kept to a minimum.

Smoking

Smoking activities were dominated by the launch of the anti-smoking drug Zyban ® in September 2000. In preparation, one advisor in Alderney and two additional part time advisors in Guernsey were recruited. Yet Guernsey Quitline staff were initially overwhelmed. They answered up to 15 calls a day, but this has now dropped to much more manageable levels. Over 1000 clients have been seen since September, and the results of a trial looking at success rates are now awaited.

The Assistant Health Promotion Officer has worked closely with GASP particularly to organise the recruitment and training of the two new staff and assisting in a variety of the Project's fun and educational activities.

She also ran three training days on smoking cessation for young people for teachers, youth workers and school nurses to prepare for the launch of GASP's Youth Quitline and worked with the project workers and the UK's Apause Project to adapt it for use in smoking education. This peer-led schools work involved 16 Year 10 students teaching Year 7 pupils, and its success has led to its being repeated in September. The Assistant Health Promotion Officer was also selected to attend a European Conference on young people and smoking in Finland, which proved to be very informative as well as confirming that Guernsey is one of the front runners in implementing community-wide anti-smoking measures.

Healthy Schools

In conjunction with the Primary Personal, Social and Health Education Co-ordinator, support was given to the Amherst Junior, St. Sampson's Infants and Vauvert Primary Schools to gain the National Health School Standard. This included meetings with staff, provision of resources, assistance in setting up press calls and help with targets and evaluation. Following a visit from a UK validator, all three schools were successful and another three have now started on the award.

The Unit also part-funded a training day for secondary schools on the use of 'circle time' strategies to teach PSHE and supported the PSHE Co-ordinator in work in primary schools and in developing an island PSHE scheme of work. In March the Unit facilitated an exhibition of seventeen different agencies that are able to support personal social and health education exhibitions in schools.

Physical Activity

Initiatives to promote physical activity included participation in the European and Guernsey *'Car-free'* days, and the Health Promotion Officer is a member of the States Traffic Committee's *'Vulnerable Road Users' Working Party'*. A demonstration *'Walking Bus'* was organised with the Police Road Safety Officer, and St. Sampson's Infant School and seven schools took part in *'Walk to School'* Week. In conjunction with Beau Séjour, a regular exercise class for women on low incomes was run, which has proved to be very popular, and the *'exercise on prescription'* scheme was expanded to four sessions per week.

In conjunction with the Sports Development Unit, a new *'Walking the Way to Health'* programme began in May 2001. 16 volunteer walk leaders were trained by a UK British Heart Foundation facilitator. There are now five 30-minute walks each week with two leaders per walk to ensure participants walk at a safe but effective pace.

Child Accident Prevention

The Health Promotion Officer attended the RoSPA Home Safety Congress in the UK and joined five other members of the Guernsey Child Accident Prevention Group at their Jersey equivalents' seminar to hear about the latest initiatives in injury prevention. Cooperation from HM Greffier and *'Aladdin's Cave'* now enables all new parents to receive two magazines on safety for the under-fives, and the Group staffed a very successful Garden Safety Exhibition brought from the UK to Floral Guernsey by the Trading Standards Service.The largest event was the extension of the *'Safety Calling'* Challenge for Year 6 pupils, which enabled nearly 700 children to attend over a period of 7½ days. The event involved a major commitment of resources from the agencies involved and from the venue, Oakvale School, but the children thoroughly enjoyed their visit, and it was highly praised by teaching staff.

The year ahead

The next project planned is to train another group of *'Live for Life'* tutors to enable the Unit to expand the healthy lifestyle sessions available. There will also be projects to follow up the health promotion priority setting meetings held at the beginning of the year, particularly in the areas of sexual health and alcohol.

Miss Yvonne Le Page,
Health Promotion Officer

Table 5.0

Notification of Communicable Diseases 2000

	1995	*1996*	*1997*	*1998*	*1999*	*2000*
Measles	2	1	0	0	0	**0**
Mumps	0	0	0	0	0	**1**
Rubella	4	6	0	0	0	**1**
Whooping Cough	6	0	0	0	1	**5**
Food Poisoning	138	160	171	189	237	**246**
Hepatitis A	0	0	2	0	0	**3**
Hepatitis B	2	0	2	3	1	**2**
Hepatitis C	1	1	0	2	0	**0**
Meningitis	4	4	3	4	0	**11**
Tuberculosis	6	4	0	3	6	**2**
Malaria	0	0	0	0	0	**0**
Scarlet Fever	1	1	0	4	1	**0**
Psittacosis	5	0	0	0	0	**0**
Dysentery	0	0	0	0	0	**0**
Q Fever	0	0	2	1	1	**0**
Confirmed HIV carriage	1	3	0	2	3	**1**
AIDS	1	1	1	0	0	**0**

Chapter Five

Communicable Disease Control and Sexual Health

Outbreak of meningococcus C disease

The year 2000 started tragically with nine cases of, and two deaths from, meningococcal C disease. In several of these cases, links could be established.

Fortunately, following the further implementation of the planned meningococcal C immunisation programme, no further cases occurred after March 2000. Since the immunisation programme, there has been an 85% decrease in incidence of meningococcal C disease in the United Kingdom and no further cases in Guernsey.

Around 18,500 doses of meningococcus C vaccine were given over a 15-month period (around 8,500 through family practitioners' surgeries and a further 10,000 through special sessions organised by the School Nurses). Effective team-work was essential, and special thanks are due to the Chief Pharmacist and Pharmacy staff at the Princess Elizabeth Hospital, to family practitioners and their practice nurses who were responsible for the pre-school immunisation programme, and to the School Nurses who organised special sessions at the various secondary schools. As a result, all students up to 18 years have been offered the highly effective meningococcus C vaccine, and hopefully deaths and serious illness from meningococcus C should now become an unhappy memory of the past.

MMR immunisation and unfounded fears

In contrast to the clear benefit of immunisation in this life-threatening disease, there has continued to be further unsubstantiated publicity about the possible risks of MMR vaccine. All expert opinion is in agreement that the current MMR vaccine is safe and effective when given in this combination, and we continue to make all possible efforts to encourage parents to have their children immunised.

True risks of tuberculosis

Tuberculosis continues to be in the news with an increased incidence in the United Kingdom due to increases in inner-city and immigrant populations. We have no evidence of tuberculosis transmission in Guernsey in recent years, and all cases have been due to reactivation of old disease or found to have been contracted abroad. There continues to be a lot of pressure from parents to have their children immunised, in complete contrast to the situation with MMR. It is important however to stress that immunisation against tuberculosis is much less than 100% effective and it may wane in effect with time. In the recent UK school outbreak in Leicester, the majority of the affected children had been immunised. We still believe that our policy of selected immunisation of high-risk individuals is correct, and the evidence supports this.

Sexual Health Clinic - KC60 Reporting - Year 2000 (Part A)

Code	Condition		Male Total	of which homosexually acquired	Female Total
A1, A2	Primary and secondary infectious syphilis	1	0		1
A3	Early latent syphilis (first 2 years)	2	1		1
A4, A5, A6	Other acquired syphilis	3	1	1	0
A7	Congenital syphilis, aged under 2	4	1		0
A8	Congenital syphilis, aged 2 or over	5	0		0
A9	Epidemiological treatment of suspected syphilis	6	1		1
B1, B2	Uncomplicated gonorrhoea	7	7	2	0
B3	Gonococcal ophthalmia neonatorum	8	0		0
B4	Epidemiological treatment of suspected gonorrhoea	9	2	1	0
B5	Gonococcal complications	10	0		0
C1, C2, C3	Chancroid / LGV / Donovanosis	11	0		0
C4A, C4C	Uncomplicated chlamydia infection	12	19		25
C4B	Complicated chlamydia infection	13	2		3
C4D	Chlamydia ophthalmia neonatorum	14	0		0
C4E	Epidemiological treatment of suspected chlamydia	15	22		9
C4H	Uncomplicated non-gonococcal / non-specific urethritis in males	16	34		0
C4I	Epidemiological treatment of NSGI	17	7		3
C5	Complicated non-gonococcal / non-specific infection	18	1		4
C6A	Trichomoniasis	19	0		0
C6B	Anaerobic / bacterial vaginosis and male infection	20	0		19
C6C	Other vaginosis / vaginitis / balantis	21	0		2
C7A	Anogenital candidosis	22	12		40
C7B	Epidemiological treatment of C6 and C7	23	0		0
C8, C9	Scabies / pediculosis pubis	24	3	1	1
C10A	Anogenital herpes simplex – first attack	25	5	1	8
C10B	Anogenital herpes simplex – recurrence	26	8		5
C11A	Anogenital warts – first attack	27	40	4	29
C11B	Anogenital warts – recurrence	28	9		16
C11C	Anogenital warts – re-registered cases	29	10		6
C12	Molluscum contagiosum	30	4	2	2
C13	Antigen positive viral hepatitis B	31	0		0
C14	Other viral hepatitis	32	0		1
D2A	Urinary tract infection	33	6		7
D2B	Other conditions requiring treatment at GUM clinic	34	50		31
D3	Other episodes not requiring treatment	35	105		80
E1A	Asymptomatic HIV infection – first presentation	36	1	1	0
E1B	Asymptomatic HIV infection – subsequent presentation	37	7	4	3
E2A	HIV infection with symptoms, not AIDS – first presentation	38	0		0
E2B	HIV infection with symptoms, not AIDS – subsequent presentation	39	0		0
E3A	AIDS – first presentation	40	0		0
E3B	AIDS – subsequent presentation	41	0		0
P1A	HIV antibody counselling – with testing	42	215	25	150
P1B	HIV antibody counselling – without testing	43	16	1	19
P2	Hepatitis B vaccination	44	8	7	1
P3	Family Planning	45	0		9
P4A	Cervical cytology – minor abnormality	46	0		5
P4B	Cervical cytology – major abnormality	47	0		1
	Total: all conditions	**47**	**597**	**50**	**482**

Food poisoning still a problem

Food poisoning continues to occur at a significant rate, with a steady rise in the number of laboratory-confirmed cases particularly in the summer months. The only effective prevention for this is sound food-handling techniques. Any outbreak, particularly in a catering establishment, reflects a failure of good hygiene or food handling practices. The Environmental Health Department is very active in running training sessions on correct food hygiene, and we hope that this work will soon be reflected in improved figures.

In common with the United Kingdom, the rise in food-poisoning notifications is accounted for mainly by *campylobacter.* This is a bacterium widely distributed in animal populations, but is not normally spread from person to person.

Dr Brian Parkin,
Deputy Medical Officer of Health

Sexual Health Clinic

There has been a continuing expansion in the services provided in the Sexual Health Clinic despite considerable constraints in manpower and hours.

The new site has proved to be popular with clients of both sexes and all ages, with its pleasant outlook and discreet setting.

There were three cases of infectious syphilis and one of congenital syphilis as a consequence of maternal infection. The re-emergence of syphilis at the end of the 20th century is something that many felt to be unlikely. However, in the past two years in the United Kingdom, diagnoses of syphilis have risen by 58% amongst men and by 27% amongst women. Similar increases have been observed across Europe and the USA. This confirms the importance of continued ante-natal testing for syphilis and the need for well resourced genito-urinary medicine (GUM) departments and sexual health clinics.

Gonorrhoea is the second most common sexually transmitted bacterial infection in England and Wales. Its increasing incidence, which is linked with poor reproductive and sexual health outcomes, and the development of anti-microbial resistance have made it a major public health concern. Several surveys have shown that between 10% and 12% of gonoccocal isolates diagnosed worldwide have some form of anti microbial resistance, and this is also true of gonoccocal isolates in Guernsey where the infection has been acquired abroad or homosexually.

Sexual Health Clinic - KC60 Reporting - Year 2000 (Part B)

Code and conditions	Sex	Under 15	15	16-19	20-24	25-34	35-54	45-64	65 & over	Total
A1, A2 Primary and secondary infectious syphilis	M	1				1				2
	F					1				1
B1, B2 Uncomplicated gonorrhoea	M			2	3	2				7
	F									0
B3 Gonococcal ophthalmia neonatorum	M									0
	F									0
B1, B2 uncomplicated gonorrhoea -homosexually acquired	M			1		1				2
	F									0
C4A, C4C Uncomplicated chlamydial infection	M			2	4	13				19
	F	1	1	11	7	5				25
C10A Anogenital herpes simplex - first attack	M					3	2			5
	F			2	2	3		1		8
C11A Anogenital warts - first attack	M	1		21	44	84	34	30	1	215
	F	2	3	40	32	52	15	6		150

Sexual Health Clinic - KC60 Reporting - Year 2000 (Part C)

	First attendance	**Subsequent attendances**
Total attendances in the year - as on KH09 return	**465**	**748**
Incoming telephone calls for clinical advice or results	**193**	

Chlamydia continues to be common amongst clients at the clinic, and it is interesting to note that there were 31 cases of epidemiological treatment of suspected chlamydia - that is, treatment of chlamydia negative partners of chlamydia contacts. This illustrates very powerfully the need for more sensitive tests which pick up chlamydia, in contrast with the current generation of tests that only pick up 60% of cases. Newer, more sensitive tests will enable a targeted chlamydia screening programme to be introduced, as recommended in the Chief Medical Officer's recommendations on chlamydia.

HIV and AIDS

There were 11 patients who attended the clinic with HIV disease during the year 2000, eight of whom were on combination therapy. There was one HIV-related death from cancer. HIV is a multi-system disorder, and even in patients whose HIV viral replication is well-controlled with Highly Active Anti-Retroviral Therapy (HAART), the impaired immune response may lead to aggressive malignancies and associated severe infections. There was one new HIV diagnosis during the year 2000, and this was homosexually acquired.

Dr Nick King,
Sexual Health Clinic

Family Planning Clinic (Figures 5.1 and 5.2)

The Family Planning Service has enjoyed another successful year. The figures show a 18% increase on 1999. Since receiving additional funding in 1997, the number of new clients has increased by 68% and the total number of clients seen, by 70%. Around 50% of all new clients are <20 years. We are hoping to maintain this trend, as we have re-located the service to the heart of St. Peter Port in rented accommodation above *'Poundworld'*. Since the move, we have seen a dramatic increase in our client-base.

We have also during the past year changed our charitable status to that of a 'Limited Company by Guarantee'.

We continue to offer a counselling service for termination of pregnancy. The figures remained the same as in 1999, with 39 clients referred and seen by the counsellor.

Mrs Sue Le Page,
Manager - Guernsey Family Planning Clinic

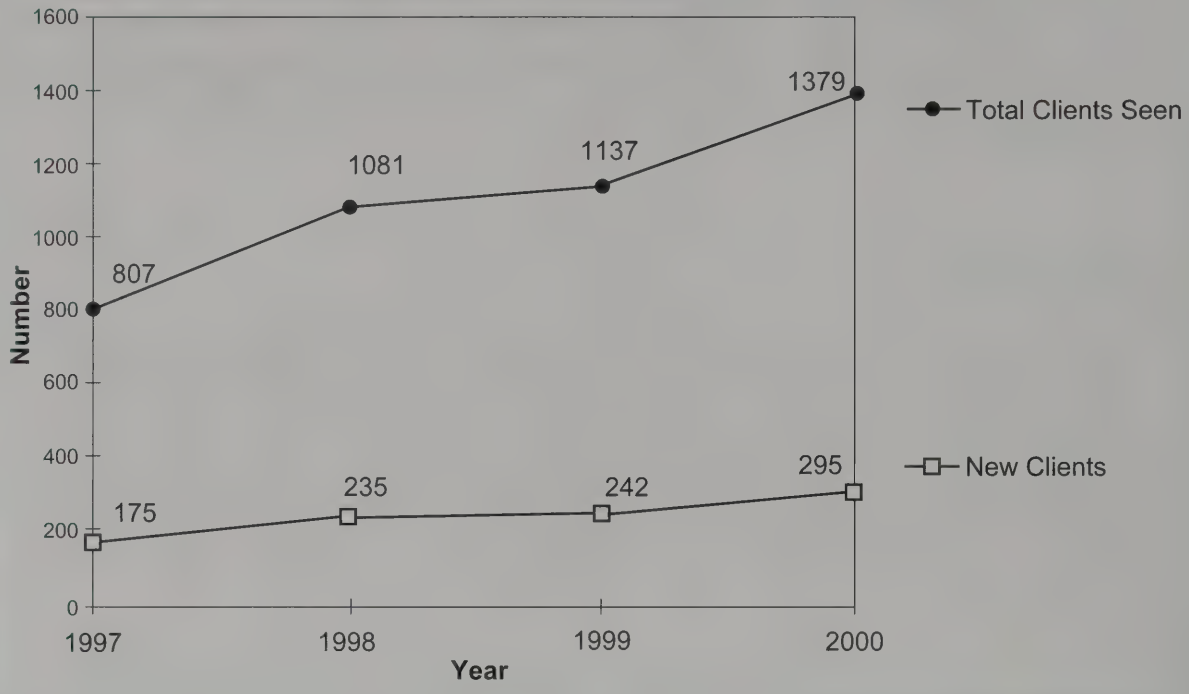


Figure 5.1 - Guernsey Family Planning Clinic New and Total Clients seen 1997-2000

Source: Guernsey Family Planning Clinic

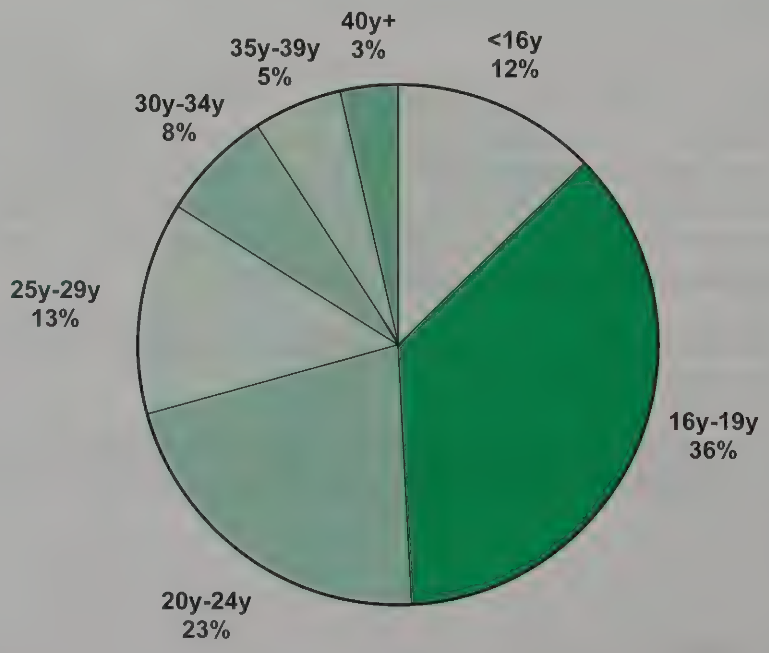


Figure 5.2 - Guernsey Family Planning Clinic New Clients by Age - 2000

Source: Guernsey Family Planning Clinic

Abortions: Guernsey and the UK

It is a requirement of the *'Abortion (Guernsey) Law 1997'* that all lawful abortions performed in Guernsey be notified to the Medical Officer of Health, whilst abortions performed in England on women normally resident in the Bailiwick are notified to the Department of Health in London.

During **2000**, there were **114** lawful terminations of pregnancy (**89** were performed in Guernsey and **25** in England). **17** were to girls under the age of **20** (**13** in Guernsey and **4** in England) and another **18** to women over the age of **35** (**13** in Guernsey and **5** in England). **23** (**20%**) of terminations performed were amongst women who declared themselves to be married.

According to the *'Discussion Document'* published in the lead-up to the States Debate on *'Contraception, Unplanned Pregnancy and Abortion'* in 1996, legal abortions performed on Bailiwick residents in England and Wales during the period 1990-1994 ranged between **105** and **155** annually. Provision for lawful abortions to be performed in Guernsey under the strict conditions of the *'Abortion (Guernsey) Law 1997'* has not yet led to any apparent rise in the total number of lawful abortions performed. At **177** per 1000 live births, they remain some **22%** lower than the **227** abortions per 1000 live births recorded in England and Wales.

Figure 5.3 - Guernsey - Births, and Terminations of Pregnancy 1993-2000

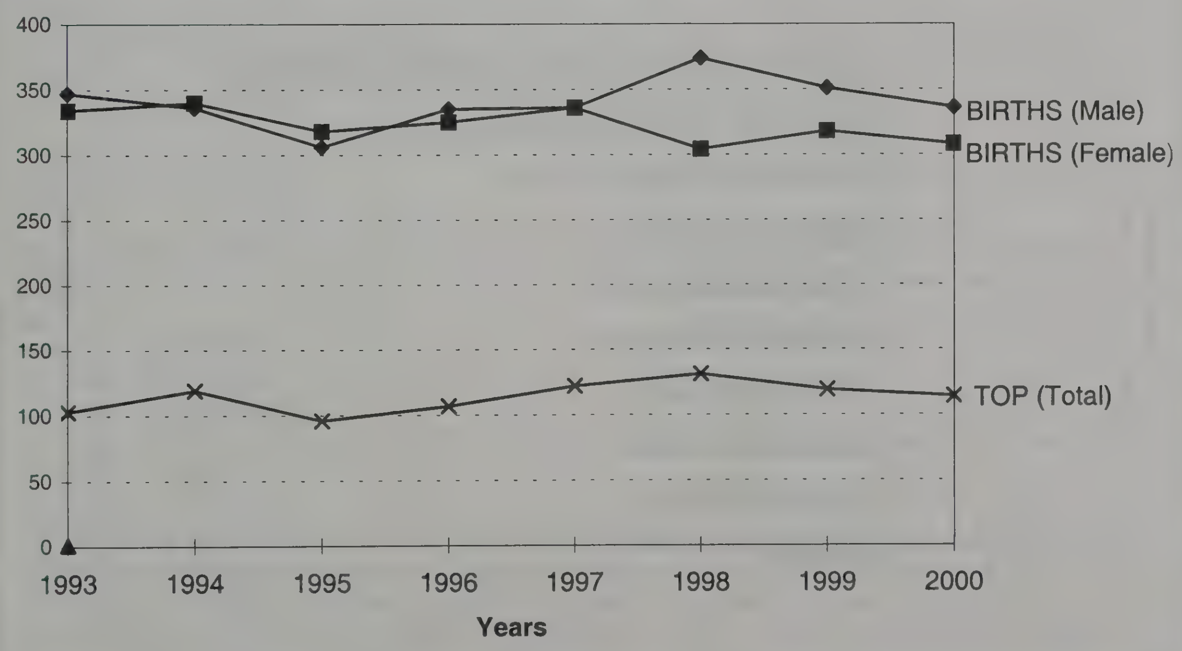


Figure 6.1 Top 10 Reasons for Admission to Princess Elizabeth Hospital

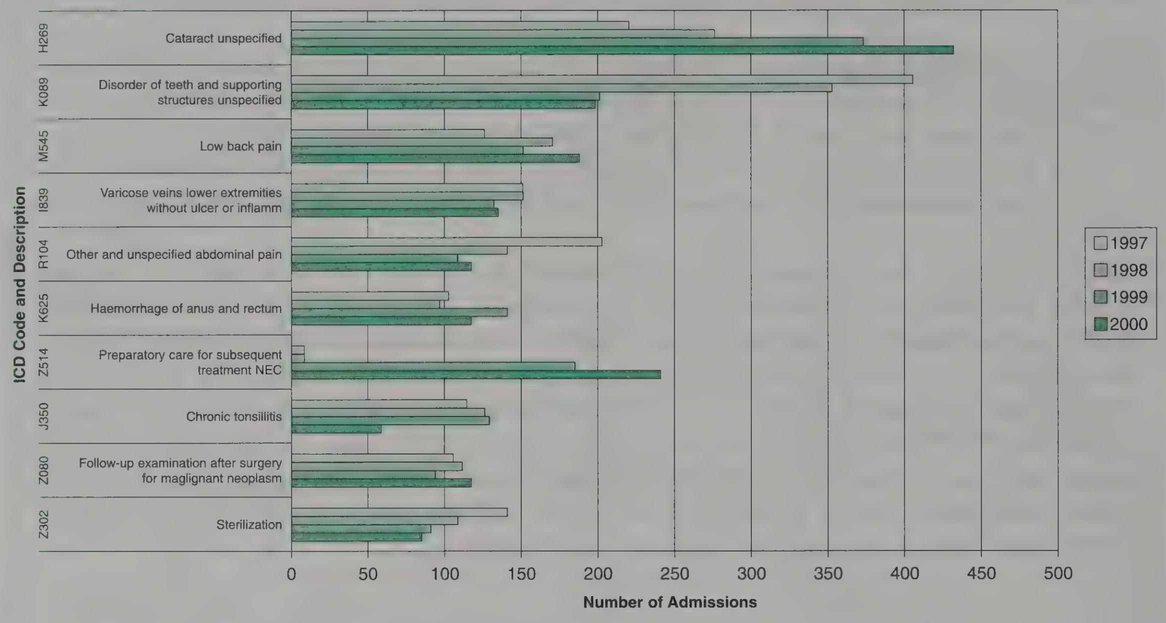
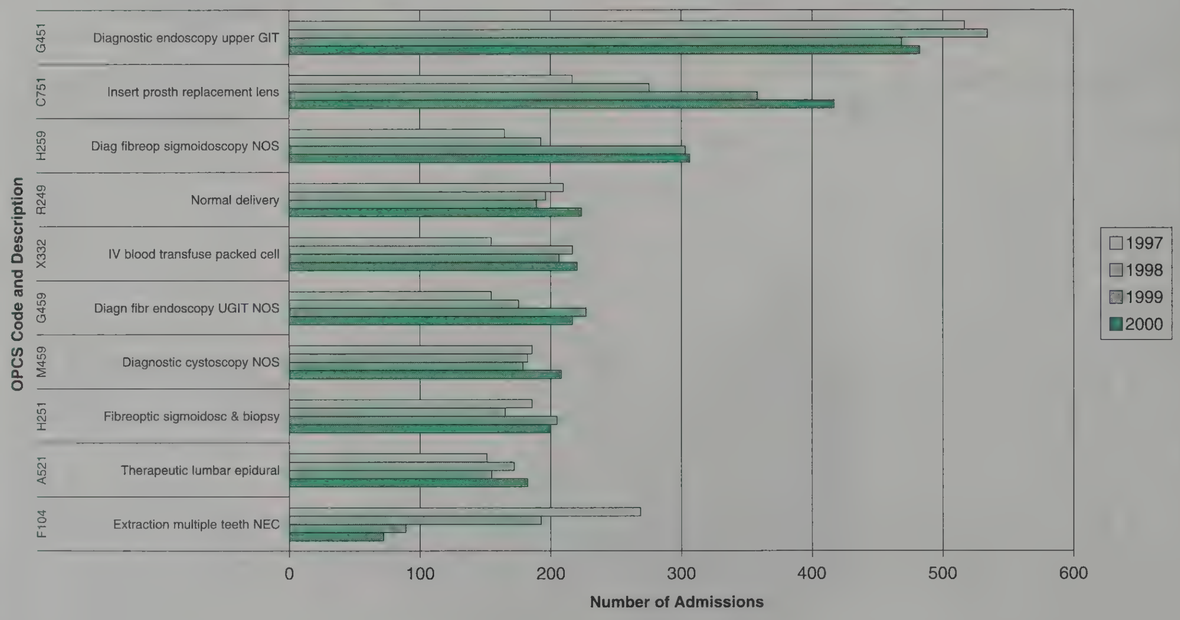


Figure 6.2 Top 10 Procedures Performed



Chapter Six

Health Strategy Unit

Introduction

As a result of management restructuring within the Board of Health, healthcare information, clinical coding, clinical audit and public health databases have been reorganised into a cohesive Health Strategy Unit, the objectives of which are:

- to identify the health needs of the population of Guernsey
- to support service planning
- to monitor the quality, standard and cost-effectiveness of the services provided
- to demonstrate the effectiveness of care and treatment given in terms of health outcomes
- to assess how effectively the needs of clients are met.

To achieve this, a considerable amount of training and skills transference continues to occur. All members of staff will be fully trained to perform electronic data analysis, reducing the amount of time spent in manual data collection, except in the case of the very specialist function of clinical coding.

Healthcare Information Service

The Healthcare Information Service, established in 1999, originally consisted of one full-time member of staff with a remit to provide a management information service to the management team and clinicians at the Princess Elizabeth Hospital. This service has expanded significantly employing an additional 1.56 wte. staff and broadening its remit to include all Board of Health Departments.

The healthcare information service can now provide comprehensive datasets for:

- in-patients
- day cases
- out-patients
- accident & emergency
- maternity.

The data is extracted from the EDS PAS system, and after a significant amount of effort all import procedures are now fully automated. Data is available for the Princess Elizabeth, Castel and King Edward VII Hospitals. Whilst a considerable amount of time has been dedicated to building these datasets, it is recognised that there is a considerable amount of data collated which remains under-utilised. In the coming year, the Health Information Service will develop a structured plan to make this untapped data available for analysis.

In addition to a significant amount of *ad hoc* work with both clinicians and managers, the Service provides a comprehensive quarterly report to the Board. The processes involved in compiling this report have now also been fully automated. This allows the health information team to begin compiling outcome focussed clinical reports and performance indicators for Guernsey healthcare. It is hoped that with support from UK-based information providers we will soon be able to produce Guernsey-population performance indicators with comparative UK population data. This will support both the clinical audit and clinical governance functions in Guernsey.

The Health Information Service is also involved in designing several databases to enable healthcare staff to collate information electronically rather than manually. Current projects comprise the design and implementation of a psychology services database, a dietetics database and work to replace the existing *'Drug Concern'* database. Previous projects include the re-design of the public health deaths database and the design of a health visitors' database to collate children-at-risk scores. The healthcare information team in collaboration with IM&T are currently investigating the purchase of scanning software, which will enable questionnaires to be compiled and the results to be scanned electronically to reduce the need for manual data-entry.

Monitoring data quality continues to be a priority within the service, with significant improvements being seen in both theatre and A&E data-quality. Since the loss of the IT Nurse Training post, data quality awareness improvement is now ensured through a collaborative effort shared between the IM&T Department and the Healthcare Information Service. Clinical staff are being trained in good data entry practice by IM&T training staff.

The Service has recently conducted structured interviews with key members of staff to examine the level of awareness and appropriateness of the Healthcare Information Service's involvement. This report will guide healthcare information provision in the future.

Clinical Coding

Clinical coding continues to be an integral part of health strategy functions. Coding averages 65 sets of medical records per day between 1 full time and 2 part time staff members across all three hospitals. It is hoped that contract negotiations with the Medical Specialist Group will reduce the time taken to provide discharge summaries, thus enabling the clinical coders to balance their workload more effectively and the Healthcare Information Service to extract OPCS-4 and ICD-10 codes in a more timely manner.

The Clinical Coding Department at the PEH has recently undertaken to code all previously uncoded episodes collected since 1995 where this is possible. This has enabled the Health Information Service to refresh coded data and give a more complete picture of clinical activity at the PEH.

All clinical coding and healthcare information staff recently completed an ICD-10 and OPCS-4 refresher course provided on site by visiting clinical coding specialists from the UK. The course tutors validated the high quality of clinical coding at all three hospitals and highlighted the need for ongoing training if this is to be maintained. In the light of this, coders at the PEH will be travelling to the UK to attend workshops in specialist orthopaedic and neoplasm coding.

Demonstrating continuing commitment to good coding practice and the provision of high quality clinical coding, the service has arranged for an external audit of 100 case notes to be conducted in Guernsey hospitals at the end of 2001.

Clinical Audit

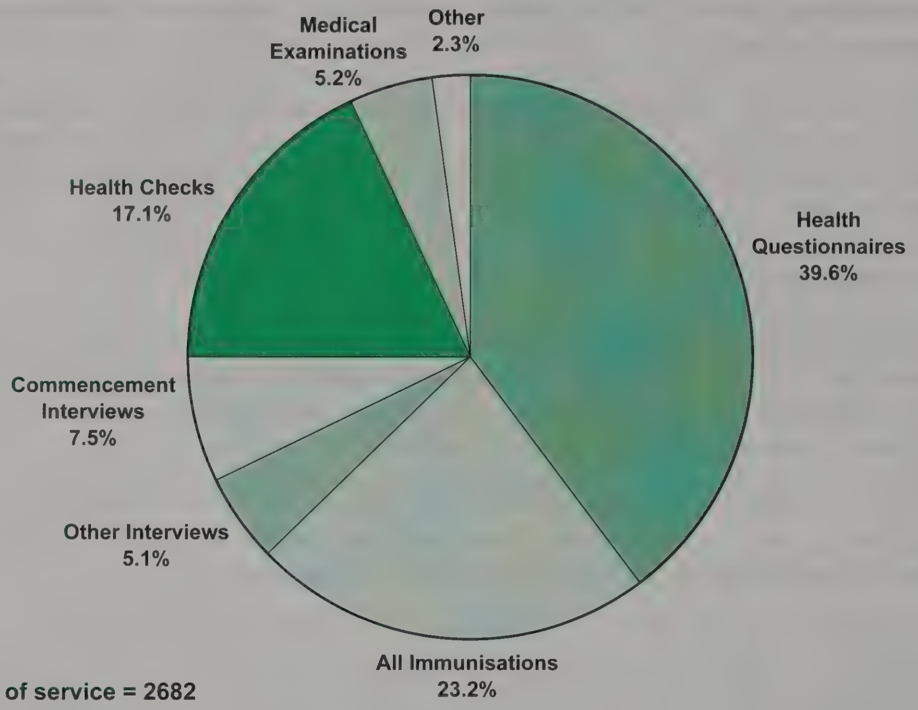
A comprehensive clinical audit programme is continuing at the PEH. The focus is being moved from *ad hoc* audits to those identified and recommended within the various *'National Service Frameworks'* and by the National Institute of Clinical Excellence (NICE).

Where appropriate, audit results are presented at the academic half-day sessions by the Clinical Audit Nurse and the clinician involved. Clinical audit reports are produced and circulated on a regular basis.

As part of the service's commitment to training and education, Morag Fitzpatrick Clinical Audit Nurse attended a *'Clinical Audit- The Cornerstone of Quality'* conference in York. In addition to this, she has passed her Higher Education and Nursing Studies Diploma by correspondence.

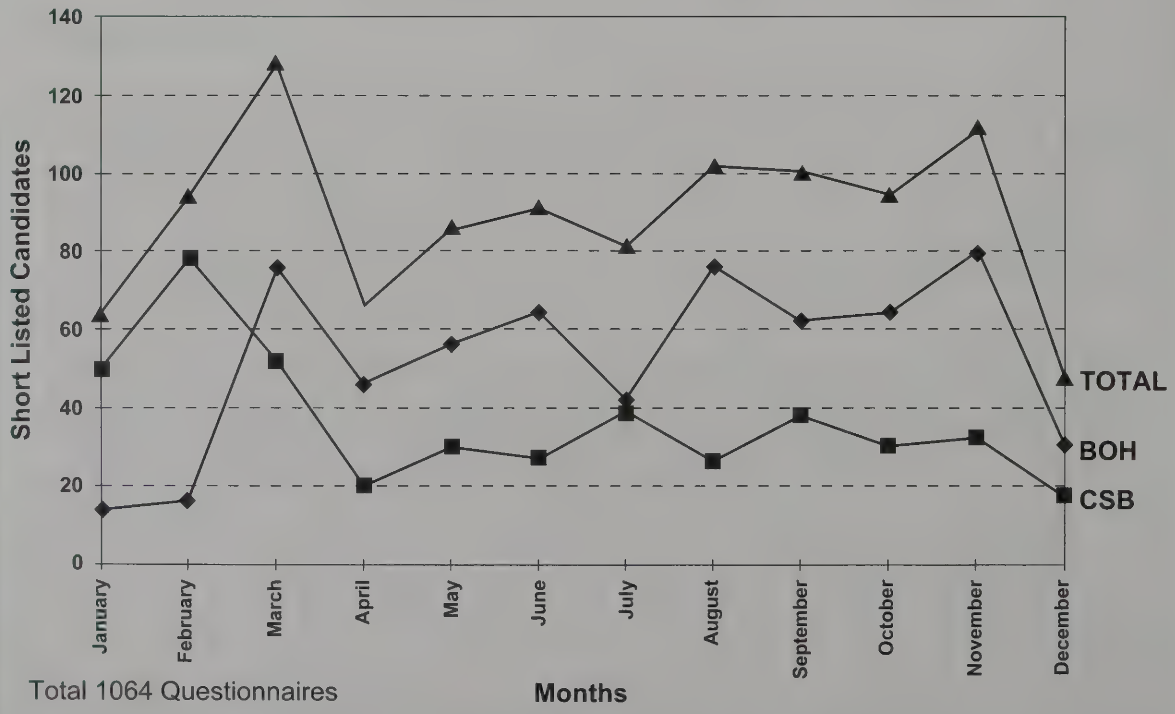
Ms Allyson Huntington,
Healthcare Information Manager

Figure 7.1 - Occupational Health Services by type of service 2000



Total of service = 2682

Figure 7.2 - Occupational Health Health Questionnaires - 2000



Total 1064 Questionnaires

Chapter Seven

Occupational Health Service

The full-time Occupational Health Nurse (OHN) continues to provide professional services with a part-time Secretary who provides the administrative support. The part-time position of Occupational Health Medical Officer (OHMO) became vacant during 2000, and we were unsuccessful in recruiting locally for this post. We are actively seeking an appropriately qualified medical doctor from the United Kingdom. In the meantime, the Director of Public Health has supported the service by sharing with us his expertise in Occupational Health Medicine.

The accompanying graphs demonstrate a 7% increase in overall activities undertaken by the OHN and a 23% increase in those undertaken by the OHMO.

Occupational Health Services - by types of service 2000 - Figure 7.1

The types of activities performed by the OHN and the OHMO are identified in the figure. There has been a 9% overall increase in activities, compared with 1999, but compared with 1997 a 55.3% increase.

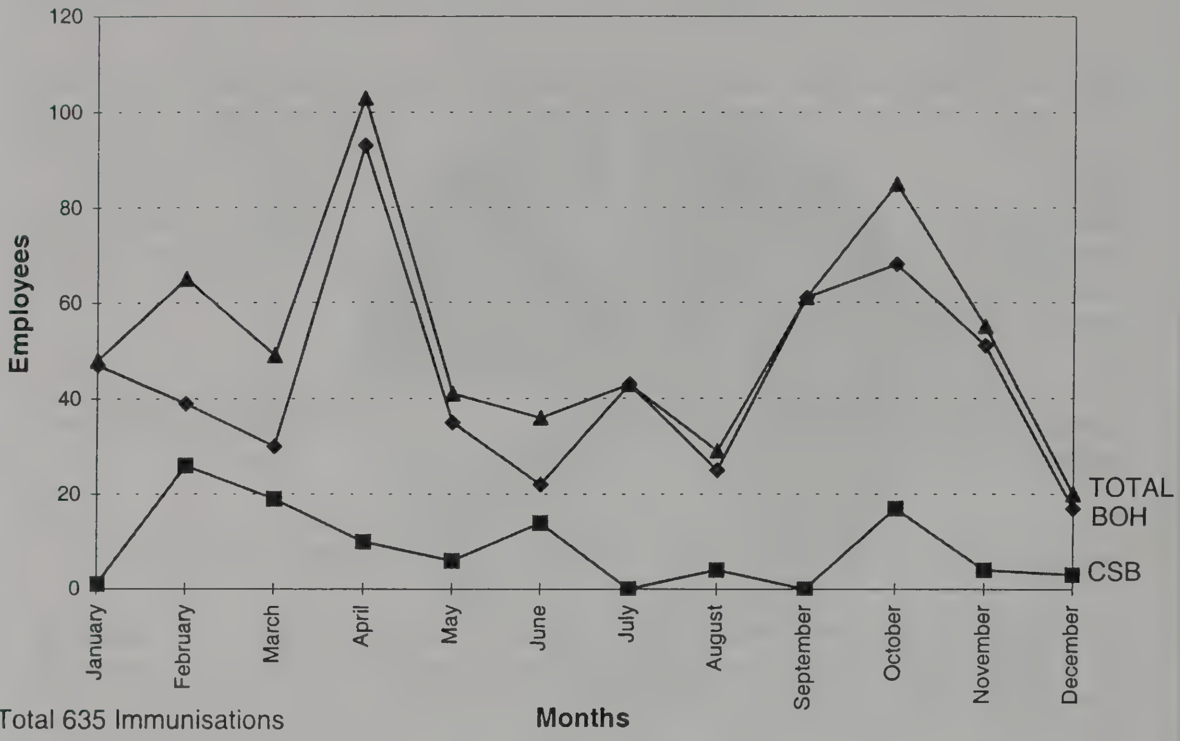
Pre-employment screening of health questionnaires by month - Figure 7.2

For the first time there has been a decrease in the number of questionnaires received by the department. There are two reasons for this. Firstly, it demonstrates the difficulties experienced by the Board of Health in recruiting employees and particularly nurses. Secondly, in conjunction with the Personnel Department and line managers, an improved system has been developed to ensure that we receive health questionnaires only from short-listed candidates. During 2000, there have been only 3 people who have been unsuccessful in fulfilling their pre-employment medical criteria.

Immunisation by month - Figure 7.3

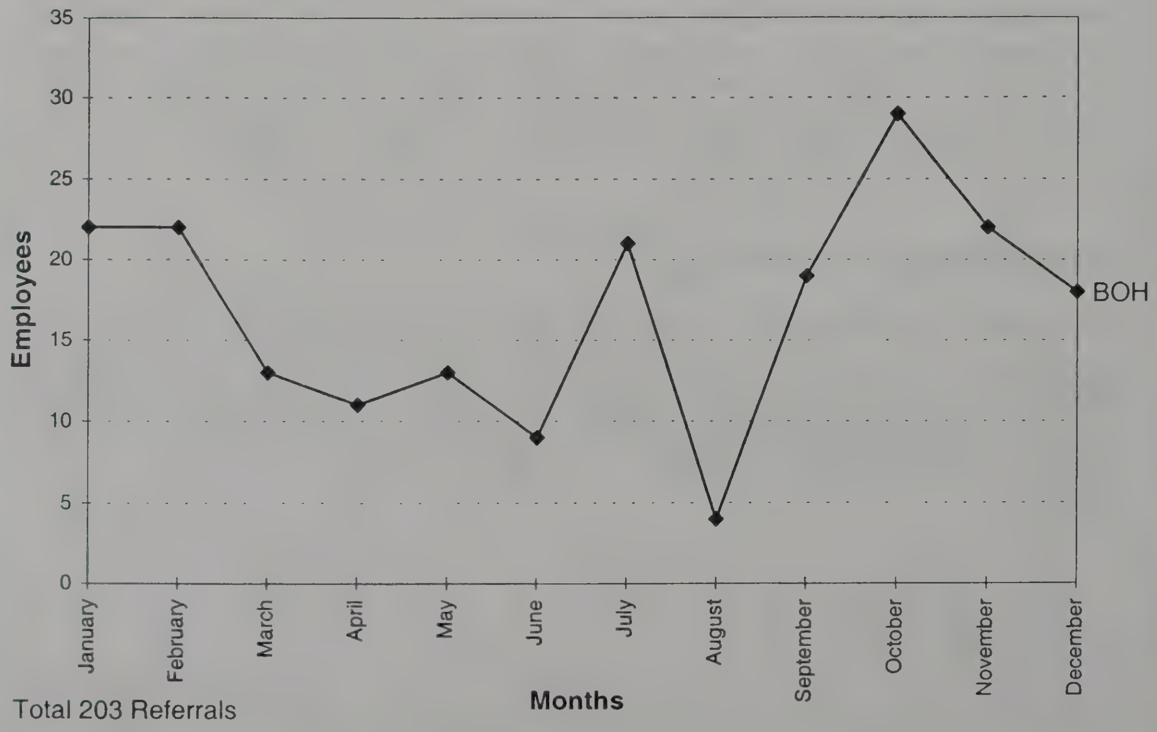
The OHN provides this service on two Board of Health sites to ease employees' access to the Immunisation Clinic. There was a 32% increase in the uptake of hepatitis B vaccine during 2000. This may be due to the recruitment of non-local nurses whose country of origin does not make this vaccine freely available to them.

Figure 7.3 - Occupational Health Immunisations by month - 2000



Total 635 Immunisations

Figure 7.4 - Occupational Health Sickness Absence Referral by month - 2000



Total 203 Referrals

Occupational Health referrals by month - Figure 7.4

One of the tasks of the OHN is to minimise and prevent occupational ill health; another is to be available for staff members who wish to access specialist advice or counselling. The related graph represents the number of employees who have been seen by the OHN and have been referred to the department by their line manager for impartial specialist advice. All medical information remains confidential, but the line manager will be given both advice on the employee's fitness for full duties and recommendations on any change of work practices needed to prevent further work-related absence.

Mrs Pam Smith
Occupational Health Nurse

Chapter Eight

Guernsey and Alderney - Vital Statistics

8.1 Births and Birth-related Data

8.2 Deaths and Death-related Data

8.3 Guernsey Deaths by ICD-10 Codes and Age Groups 2000

8.4 Alderney Vital Statistics

8.1 Guernsey - Vital Statistics 2000

● Births and Birth-related Data

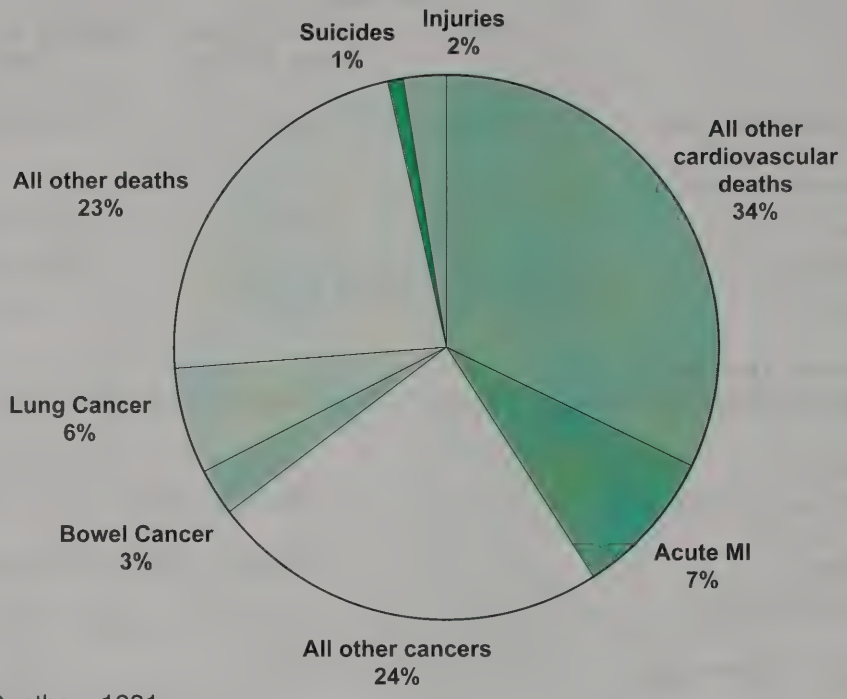
	Guernsey 2000	 5 Year Mean 1994-1998	England & Wales 1996
Estimated Mid Year Resident Population:	60,441✂	58,867	52,010,000
• Males	29,131✂	28,297	28,860,000
• Females	31,310✂	30,570	27,948,000
• M : F	0.93	0.93	0.96
Population Density [Area 63.1Km²]:	958	933	51.8
Marriages:	343	345	279,000
• Marriages/000	5.7	5.9	5.4
Divorces:	173	165	157,100
• Divorces/000	2.9	2.8	3.0
Divorces : Marriages	0.50	0.48	0.56
Births:	644	662	649,500
• Males	336	337	341,300
• Females	308	323	308,200
• M : F	1.09	1.04	1.05
Births outside Marriage:	224	182	232,700
• % All Births	34.8%	28%	35.8%
Stillbirths:	4	4.2	3,539
• Rate/000 Live Births	6.2	6.3	5.4
Early Neonatal deaths:	4	*	3.0
Late Neonatal deaths:	0	2.2	0.9
Infant Deaths:	4	3	3,990
• Infant Death Rate/000	6.2	4.5	6.1
Crude Birth Rate/000	10.6	11.2	12.5
Natural Fertility Rate:	52.0	51.5	59.8
Natural Increase per annum:	0.12%	0.20%	0.16%

*not separately calculated

✂estimated

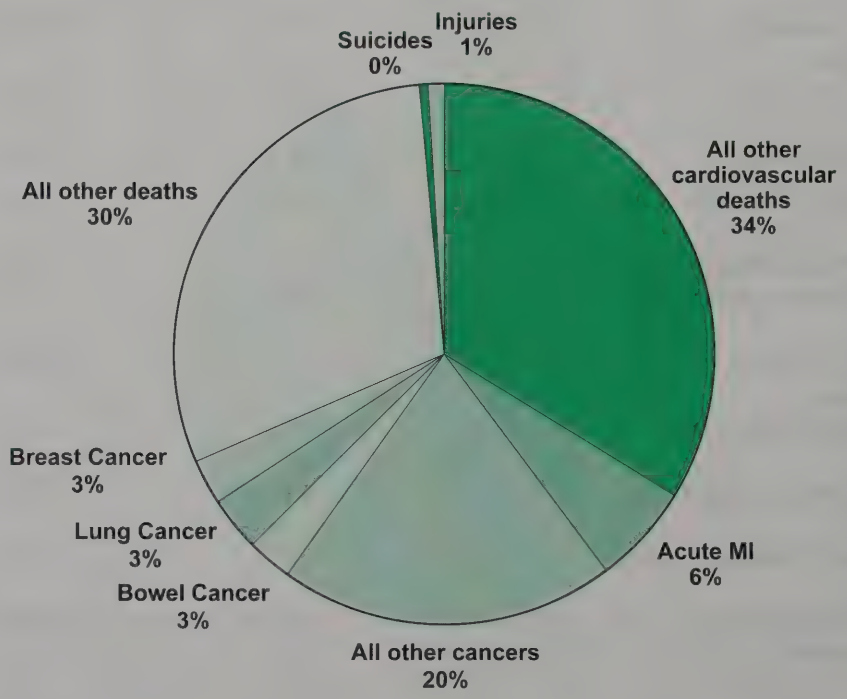
Figure 8.2 - Deaths in Guernsey - By Cause 1996-2000

MALES



Total Male Deaths = 1331

FEMALES



Total Female Deaths = 1518

8.2 Guernsey - Vital Statistics 2000

● Deaths and Death-related Data

	Guernsey		
	2000	5 Year Mean 1994-1998	England & Wales 1996
Total Deaths:	569	592	563,000
• Males	266	289	269,800
• Females	303	305	293,200
• M : F		0.95	0.92
Crude Death Rate:/100		10.1	10.8
Circulatory Deaths (I00-I99):			
• Males - Rate/00,000	315.8✂	406.4	424
• Females - Rate/00,000	376.9✂	388.6	424
Cancer Deaths (C00-C97/D00-D48):			
• Males - Rate/00,000	295.2✂	298	282
• Females - Rate/00,000	236.4✂	261	251
Lung Cancer Deaths (C34):			
• Males - Rate/00,000	78.9✂	79.2	80.2
• Females - Rate/00,000	51.1✂	38.6	42.0
Breast Cancer Deaths (C50):			
• Females - Rate/00,000	25.5✂	42.5	47.4
Alcoholic Liver Disease (K70):			
• Males - Rate/00,000	6.9✂	12.7	8.5
• Females - Rate/00,000	12.8✂	7.9	5.5
Injury Deaths (S00-X59):			
• Males - Rate/00,000	17.2✂	41.7	27.7
• Females - Rate/00,000	19.2✂	17.1	17.6
Suicide Deaths (X60-X84):			
• Males - Rate/00,000	10.3✂	12.7	11.0
• Females - Rate/00,000	0✂	6.5	3.0

✂on estimated population

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group I Infectious and Parasitic Diseases																
A16	Respiratory TB, not confirmed bacteriologically or histologically	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
A39	Meningococcal infection	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0
A41	Other Septicaemia	1	5	0	0	0	0	0	0	0	0	0	0	0	2	1	3
A70	Chlamydia psittaci infection	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Total Group I	4	6	0	0	0	0	2	0	0	0	0	0	1	3	1	3
	Group II Neoplasms																
C06	Malignant neoplasm of other and unspecified parts of mouth	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C07	Malignant neoplasm of parotid gland	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C15	Malignant neoplasm of oesophagus	7	4	0	0	0	0	0	0	0	0	4	0	0	1	3	3
C16	Malignant neoplasm of stomach	4	0	0	0	0	0	0	0	0	0	0	0	3	0	1	0
C17	Malignant neoplasm of small intestine	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
C18	Malignant neoplasm of colon	2	5	0	0	0	0	0	0	0	0	0	0	2	0	0	5
C19	Malignant neoplasm of rectosigmoid junction	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C20	Carcinoma of the rectum	4	1	0	0	0	0	0	0	0	0	1	0	1	0	2	1
C22	Malignant neoplasm of liver & intrahepatic bile duct	2	1	0	0	0	0	0	0	0	0	0	1	1	0	1	0
C23	Malignant neoplasm of gallbladder	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C25	Malignant neoplasm of pancreas	1	7	0	0	0	0	0	0	0	0	0	1	0	1	1	5
C34	Malignant neoplasm of bronchus and lung	23	16	0	0	0	0	0	0	0	0	5	5	6	6	12	5
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C40	Malignant neoplasm of bone and articular cartilage of limb	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
C43	Malignant melanoma of skin	2	1	0	0	0	0	0	0	0	0	2	0	0	0	0	1
C49	Malignant neoplasm of other connective and soft tissue	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C50	Malignant neoplasm of breast	0	8	0	0	0	0	0	0	0	0	0	3	0	1	0	4
C52	Malignant neoplasm of vagina	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1
C53	Malignant neoplasm of cervix uteri	0	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
C56	Carcinoma of the ovary	0	5	0	0	0	0	0	0	0	0	0	1	0	2	0	2
	c/f	51	55	0	0	0	0	0	1	0	0	13	13	13	13	25	28

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	b/f	51	55	0	0	0	0	0	1	0	0	13	13	13	13	25	28
C61	Carcinoma of the prostate	16	0	0	0	0	0	0	0	0	0	0	0	5	0	11	0
C64	Malignant neoplasm of the kidney	0	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0
C67	Malignant neoplasm of bladder	6	2	0	0	0	0	0	0	0	0	0	0	4	1	2	1
C71	Malignant neoplasm of brain	3	1	0	0	0	0	0	0	1	0	1	0	1	0	0	1
C76	Malignant neoplasm of other and ill-defined sites	2	3	0	0	0	0	0	0	0	0	0	0	2	1	0	2
C79	Secondary malignant neoplasm of other sites	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1
C80	Malignant neoplasm without specification of site	4	1	0	0	0	0	0	0	0	0	1	0	0	0	3	1
C85	Other & specified types of non-Hodgkin's lymphoma	1	3	0	0	0	0	0	0	0	0	1	0	0	1	0	2
C90	Multiple myeloma and malignant plasma cell neoplasms	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
C91	Lymphoid leukaemia	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
C92	Myeloid leukaemia	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C93	Monocytic leukaemia	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C95	Leukaemia of unspecified cell type	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
	Total Group II	86	74	0	0	0	0	0	1	1	0	16	14	26	20	43	49
	Group III Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism																
D64	Other anaemias	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
D65	Disseminated intravascular coagulation	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Total Group III	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	Group IV Endocrine, nutritional & metabolic diseases																
E10	Insulin-dependent diabetes mellitus	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Total Group IV	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Group V Mental and behavioural disorders																
F10	Mental and behavioural disorders due to use of alcohol	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Total Group V	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total M	Total F	Under 1 M	Under 1 F	Age 1-14 M	Age 1-14 F	Age 15-24 M	Age 15-24 F	Age 25-44 M	Age 25-44 F	Age 45-64 M	Age 45-64 F	Age 65-74 M	Age 65-74 F	Age 75+ M	Age 75+ F
	Group VI Diseases of the nervous system																
G20	Parkinsons disease	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
G30	Alzheimer's disease	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	Totals Group VI	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
	Group IX Diseases of the circulatory system																
I11	Hypertensive heart disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I21	Acute myocardial infarction	15	20	0	0	0	0	0	0	0	0	0	2	3	3	12	15
I24	Other acute ischaemic heart disease	1	2	0	0	0	0	0	0	0	0	1	0	0	1	0	1
I25	Chronic ischaemic heart disease	27	25	0	0	0	0	0	0	0	0	7	1	8	5	12	19
I26	Pulmonary embolism	0	3	0	0	0	0	0	0	0	0	0	1	0	0	0	2
I27	Other pulmonary heart diseases	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I35	Nonrheumatic aortic valve disorders	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I42	Cardiomyopathy	4	4	0	0	0	0	0	0	1	0	2	0	0	1	1	3
I46	Cardiac arrest	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1
I48	Atrial fibrillation and flutter	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
I50	Heart failure	10	14	0	0	0	0	0	0	1	0	0	0	1	1	8	13
I61	Intracerebral haemorrhage	3	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0
I63	Cerebral infarction	4	7	0	0	0	0	0	0	0	0	0	1	0	0	4	6
I64	Stroke (or cerebrovascular accident)	12	25	0	0	0	0	0	0	0	0	1	0	0	1	11	24
I66	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I67	Other cerebrovascular diseases	5	4	0	0	0	0	0	0	0	0	1	0	0	1	4	3
I70	Artherosclerosis	4	2	0	0	0	0	0	0	0	0	2	0	0	0	2	2
I71	Aortic aneurism and dissection	4	3	0	0	0	0	0	0	0	0	0	0	1	0	3	3
I73	Other peripheral vascular diseases	2	2	0	0	0	0	0	0	0	0	1	0	1	1	0	1
I82	Other venous embolism and thrombosis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total Group IX	92	119	0	0	0	0	0	0	2	0	15	6	16	16	59	97

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group X Diseases of the respiratory system																
J11	Influenza, virus not identified	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J18	Pneumonia	21	34	0	0	0	0	0	0	0	0	0	0	4	1	17	33
J43	Emphysema	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
J44	Other chronic obstructive pulmonary disease	11	6	0	0	0	0	0	0	0	0	1	1	2	0	8	5
J60	Coalworker's pneumoconiosis	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J61	Pneumoconiosis due to asbestos and other mineral fibres	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
J84	Other interstitial pulmonary diseases	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	Totals Group X	38	41	0	0	0	0	0	0	0	0	1	1	7	1	30	39
	Group XI Diseases of the digestive system																
K25	Gastric ulcer	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
K31	Other diseases of stomach and duodenum	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
K55	Vascular disorders of intestine	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K56	Paralytic ileus and intestinal obstruction without hernia	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
K57	Diverticular disease of intestine	1	3	0	0	0	0	0	0	0	0	0	0	0	1	1	2
K65	Peritonitis	3	1	0	0	0	0	0	0	0	0	0	0	0	0	3	1
K70	Alcoholic liver disease	2	5	0	0	0	0	0	0	0	1	1	2	1	2	0	0
K72	Hepatic failure, nec.	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
K74	Fibrosis and cirrhosis of liver	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
K82	Other diseases of gall bladder	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K85	Acute pancreatitis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K86	Other diseases of pancreas	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K92	Other diseases of digestive system	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
	Total Group XI	15	12	0	0	0	0	0	0	1	1	3	2	2	4	9	5
	Group XIII Diseases of the musculoskeletal system and connective tissue																
M46	Other inflammatory spondylopathies	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total Group XIII	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XIV Diseases of the genito-urinary system																
N17	Acute renal failure	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
N18	Chronic renal failure	3	3	0	0	0	0	0	0	0	0	0	1	1	0	2	2
N19	Unspecified renal failure	1	3	0	0	0	0	0	0	0	0	0	0	0	1	1	2
N39	Other disorders of urinary system	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
	Totals Group XIV	6	9	0	0	0	0	0	0	0	0	0	1	1	1	5	7
	Group XVI Certain conditions originating in the perinatal period																
P07	Disorders relating to short gestation and low birthweight, not elsewhere classified	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0
P28	Other respiratory conditions originating in the perinatal period	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
P95	Still-born	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0
	Totals Group XVI	4	3	4	3	0	0	0	0	0	0	0	0	0	0	0	0
	Group XVII Congenital malformations, deformations and chromosomal abnormalities																
Q23	Congenital malformations of aortic and mitral valves	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Totals Group XVII	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0

8.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2000

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XVIII Symptoms, signs & abnormal clinical & laboratory finding, not elsewhere classified																
R09	Other symptoms and signs involving the circulatory and respiratory systems	1	4	0	0	0	0	0	0	1	0	0	0	0	0	0	4
R54	Old age (senility)	7	24	0	0	0	0	0	0	0	0	0	0	0	0	7	24
R58	Haemorrhage, not elsewhere classified	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
R99	Other ill-defined and unspecified causes of mortality	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Total Groups XVIII	9	29	0	0	0	0	0	0	1	0	0	0	1	1	7	28
	Group XIX Injury, poisoning & certain other consequences of external causes																
S12	Fracture of neck	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
T17	Foreign body in respiratory tract	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
T59	Toxic effect of corrosive substances	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Total Groups XIX	2	1	0	0	0	0	1	0	0	0	0	0	1	0	0	1
	Group XX External causes, morbidity & mortality																
V14	Pedal cyclist injured in collision with heavy transport vehicle or bus	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
W19	Unspecified fall	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
X45	Accidental poisoning by and exposure to alcohol	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
X67	Intentional self-poisoning by and exposure to other gases and vapours	3	0	0	0	0	0	0	0	2	0	0	0	0	0	1	0
X99	Assault by sharp object	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0
Y21	Drowning and submersion, undetermined intent (male age unknown)	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Totals Group XX	5	5	0	0	0	1	0	1	2	0	1	3	0	0	1	0
	Total Deaths:	**266**	**303**	**5**	**3**	**0**	**1**	**3**	**2**	**8**	**1**	**37**	**27**	**56**	**46**	**156**	**223**

8.4 Alderney Vital Statistics - 2000

	Males	Females	Total 2000	Total 1999
Population (1996 Census):	1024	1117	**2141**	2141
• **M : F**			**0.92**	0.92
Births - In Guernsey:	8	7	**15**	13
Births - In Alderney:	0	0	**0**	1
Total Births to Alderney residents:	8	7	**15**	13
Births outside marriage:	4	4	**8**	3
Crude Birth Rate/000	-	-	**7.0**	6.5
Marriages registered in Alderney:			**9**	14
Deaths registered in Alderney:	14	15	**29**	27
Crude Death Rate/000			**13.5**	13.6
Natural Increase:*			**-14** **[-0.7%]**	**-15** **[-0.7%]**

*The natural increase is the difference between the crude birth rate and the death rates expressed as a percentage of the resident population.

9.0 Staff providing public health services 2000

Director of Public Health/Medical Officer of Health
Dr David Jeffs MRCP MFPHM FAFPHM FRACGP FRSH

Personal Assistant
Mrs Yvonne Kaill *(until December 2000)*

Data Clerk
Mrs Jenny Elliott

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS Bsc MRCP MRCGP DRCOG

Sexual Health Clinic
Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer
Mr John Cook MCIEH

Deputy Chief Environmental Health Officer
Mr Tony Rowe MCIEH

Environmental Health Officers
Mr Stan Horton MCIEH
Mr Stuart Wiltshire MCIEH
Mr Jonathon Coyde MCIEH
Mr Tobin Cook MSc
Ms Isobelle Belcher BSc MCIEH PGCE

Trainee Waste Regulation Officer
Mr Simon Penney BSc (Hons) Grad M Inst WM

Pest Control Operatives
Mr Paul Tostevin
Mr Michael Brache

Secretary
Miss Kelly Moore

Health Promotion Unit:

Health Promotion Officer
Miss Yvonne Le Page BEd(Hons) DipHE&HP RHPS

Assistant Health Promotion Officer
Mrs Gerry Grange RGN LAY Trainer RHPS

Resources Officer
Mrs Stephanie Charlwood

Secretary
Mrs Pam Marsh

Occupational Health:

Clinical Medical Officer
Dr Stephen C. M. Sweet MB ChB DA DRCOG *(until 30th June 2000)*

Occupational Health Nurse
Mrs Pam Smith RGN OHN

Secretary
Mrs Jackie Mallett